Good Accounting Obligation in Government Act (GAO-IG Act) Report

The information below addresses the requirements of the Good Accounting Obligation in Government Act (GAO-IG Act; Public Law 115-414) to provide a report identifying each public recommendation issued by the Government Accountability Office (GAO) and federal Offices of Inspectors General (OIG) which remains unimplemented for one year or more from the annual budget justification submission date. The recommendations below apply specifically to this division of HHS. Please refer to the General Departmental Management budget justification for more information on the Department's overall progress in implementing GAO and OIG recommendations.

Appendix 1: OIG-GAO Open Recommendations

Report Number	Report Title	Report Date	Recommendation Text	Concur / Non-Concur	Implementation Timeline	Implementation Status	Implementation Updates and Constraints
GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2002	To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human services should better ensure that valid methods are used to demonstrate budget neutrality, by developing and implementing consistent criteria for consideration of section 1115 demonstration waiver proposals.	Non-Concur	2020	Awaiting Disposition	In May 2018 CMS responded to request for information and source documents related to Budget Neutrality Methods. CMS has continued to provide additional information in 2019 and we awaiting further discussion with GAO.
GAO-07-214	Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency	3/30/2007	To enhance the transparency of CMS oversight and clarify and communicate the types of allowable state financing arrangements, the Administrator of CMS should provide each state CMS reviews under its initiative with specific and written explanations regarding agency determinations on the allowability of various arrangements for financing the nonfederal share of Medicaid payments and make these determinations available to all states and interested parties.	Concur	2020	In progress	Regulation under development
GAO-08-529	Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities	5/23/2008	To help states identify and address quality-of-care concerns among individuals with developmental disabilities receiving Medicaid HCBS waiver services, the Administrator of CMS should encourage states to (1) include death as a critical incident and conduct mortality reviews if they do not already do so and (2) broaden their mortality review processes if they already include death as a critical incident and conduct mortality reviews.	Concur	2019	In progress	CMS is engaging internally with leadership regarding the desired approach to monitoring and reporting of suspicious deaths in HCBS waivers and possibility of new guidance.

GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	To ensure that information entered into CMS's complaints database is reliable and consistent, the Administrator of CMS should identify issues with data quality and clarify guidance to states about how particular fields in the database should be interpreted, such as what it means to substantiate a complaint.	Concur	2020	In progress	CMS will review how particular fields in the database should be interpreted and issue clarifying guidance, including what it means to substantiate a complaint. In addition, through the State Performance Standards System, CMS is reviewing data trends to improve State performance, including looking at substantiation rates (i.e., citation rates) during complaint investigations.
GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	To strengthen CMS's assessment of state survey agencies' performance in the management of nursing home complaints, the Administrator of CMS should conduct additional monitoring of state performance using information from CMS's complaints database, such as additional timeliness measures.	Concur	2021	In progress	Every year, CMS, through its Regional Offices, uses the State Performance Standards System (SPSS) to conduct a formal assessment of whether state survey agencies fulfill their responsibilities. The SPSS provides a framework for CMS to organize and measure the value associated with the survey process overall and is comprised of three domains: frequency, quality, and enforcement. In April 2018, CMS launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance. We anticipate implementing revisions to the SPSS in FY 2020. GAO's recommendation will be reviewed in the course of the evaluation. The effort supports our ultimate goal of protecting and improving the health and safety of all individuals receiving services from all Medicare/Medicaid providers throughout the country.
GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	To strengthen CMS's assessment of state survey agencies' performance in the management of nursing home complaints, the Administrator of CMS should assure greater consistency in assessments by identifying differences in interpretation of the performance standards and clarifying guidance to state survey agencies and CMS regional offices.	Concur	2019	Awaiting Disposition	In November 28, 2017, CMS implemented revised Interpretive Guidance for surveyors (Appendix PP of the State Operations Manual) and a new survey process that all SAs are required to use, to improve consistency for identifying deficiencies. This also assisted in clarifying differences in interpretation of the performance standards. The Survey and Cert Letter that describes this revised interpretive guidance is attached, and can also be found here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-17-36.html?DLPage=1&DLEntries=10&DLFilter=phase%20&DLSort=3&DLSortDir=descending Appendix PP of the State Operations Manual is also attached. Additional information regarding revised survey protocols and interpretive guidelines can be found on the CMS webpage here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html
GAO-11-280	Nursing Homes: More Reliable Data	4/7/2011	To strengthen and increase accountability of state survey agencies' management of the	Concur	2020	In progress	Section 5080 of the State Operations Manual describes the minimum information that should be conveyed to complainants. CMS will revise the minimum information to

	and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations		nursing home complaints process, the Administrator of CMS should clarify guidance to the state survey agencies about the minimum information that should be conveyed to complainants at the close of an investigation.				guide States to inform complainants if their complaint was substantiated.
GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	To strengthen and increase accountability of state survey agencies' management of the nursing home complaints process, the Administrator of CMS should provide guidance encouraging state survey agencies to prioritize complaints at the level that is warranted, not above that level.	Concur	2020	In progress	CMS will include guidance that we expect SAs to triage complaints and facility-reported incidents at the appropriate level.
GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/7/2011	To strengthen and increase accountability of state survey agencies' management of the nursing home complaints process, the Administrator of CMS should implement CMS's proposed plans to publish state survey agencies' scores but limit publication to those performance standards that CMS considers the most reliable and clear.	Concur	2019	Awaiting Disposition	CMS considers this recommendation implemented. For the last 3 years we have published SPSS results in Admin Info Memos. The body of the memo contains a summary of the main findings of the key elements that CMS considers the most reliable and clear.
GAO-11-293R	Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement	4/5/2011	In light of the need for accurate and complete information on children's access to health services under Medicaid and CHIP, the requirement that states report information to CMS on certain aspects of their Medicaid and CHIP programs, and problems with accuracy and completeness in this state reporting, the Administrator of CMS should work with states to identify additional improvements that could be made to the CMS 416 and CHIP annual reports, including options for reporting on the receipt of services separately for children in managed care	Concur	2020	In progress	CMS and GAO on 8/12/2019. GAO stated that they understand that referral data cannot be captured and will remove that portion of the criteria for closure

			and fee-for-service delivery models, while minimizing reporting burden, and for capturing information on the CMS 416 relating to children's receipt of treatment services for which they are referred.				
GAO-11-365	End-Stage Renal Disease: CMS Should Assess Adequacy of Payment When Certain Oral Drugs Are Included and Ensure Availability of Quality Monitoring Data	3/23/2011	To help ensure that Medicare beneficiaries have access to high-quality dialysis care, the Administrator of CMS should assess the extent to which the bundled payment for dialysis care will be sufficient to cover an efficient dialysis organization's costs to provide such care when the bundled payment expands to cover oral-only ESRD drugs. The Administrator should conduct this assessment before implementing this expanded bundled payment.	Concur	2024	In progress	CMS actively working on closure, will have update after 2022.
GAO-11-791	Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care	9/23/2011	As HHS implements its current and forthcoming efforts to make transparent price information available to consumers, HHS should determine the feasibility of making estimates of complete costs of health care services available to consumers through any of these efforts.	Concur	2021	In Progress	
GAO-11-791	Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care	9/23/2011	As HHS implements its current and forthcoming efforts to make transparent price information available to consumers, HHS should determine, as appropriate, the next steps for making estimates of complete costs of health care services available to consumers.	Concur	2021	In Progress	

GAO-11-96	Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns	11/30/2010	To enhance the provision of dental care to children covered by Medicaid and CHIP, and to help ensure that HHS's Insure Kids Now Web site is a useful tool to help connect children covered by Medicaid and CHIP with participating dentists who will treat them, the Secretary of HHS should require states to verify that dentists listed on the Insure Kids Now Web site have not been excluded from Medicaid and CHIP by the HHS-OIG, and periodically verify that excluded providers are not included on the lists posted by the states.	Concur	2020	In progress	CMS will explore the viability of adding a task to our IKN data quality contract to compare excluded provider lists. 11/12/2019 CMS provided closure justification update. Currently awaiting GAO response.
GAO-12-333	Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans	4/3/2012	To improve the effectiveness of the MSP program and process for NGHPs, and to improve the agency's communication regarding the MSP process for situations involving NGHPs, the Acting Administrator of CMS should develop guidance regarding liability and no-fault set-aside arrangements.	Concur	2020	In progress	CMS is in the process of rulemaking to address the finding. An NPRM is in process and subsequently a final rule.
GAO-12-51	Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices	1/12/2012	To help ensure appropriate payments to MA plans, the Administrator of CMS should take steps to improve the accuracy of the adjustment made for differences in diagnostic coding practices between MA and Medicare FFS. Such steps could include, for example, accounting for additional beneficiary characteristics, including the most current data available, identifying and accounting for all years of coding differences that could affect the payment year for which an adjustment is made, and incorporating the trend of the impact of coding differences on risk scores.	Concur	2016	Awaiting Disposition	CMS considers this issue CLOSED: The statute provides the Secretary flexibility in terms of how CMS conducts the coding adjustment analysis. Given the complexity of measuring coding changes attributable to plan behavior, and the difficulty of measuring countervailing factors, there is not a single correct factor within the viable range of adjustment factors. Since 2010, CMS (to whom the Secretary has delegated this responsibility) has determined that differences in coding patterns exist and accordingly have determined an appropriate adjustment each year. Once CMS determined that differences in coding existed, an adjustment is required, but CMS believes there is policy discretion with respect to the appropriate adjustment factor for the payment year. For each payment year, CMS updates and reassesses the data that is used to calculate the MA coding difference adjustment factor, as part of the agency policy development process for the Advance Notice and Rate Announcement for that payment year. CMS has regularly increased this factor since the 2012 report. This is an annual decision-making process in which

							Agency leadership makes decisions regarding this factor and other payment policies.
GAO-12-81	Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations	1/18/2012	The Administrator of CMS should take steps to better align Medicare beneficiary use of preventive services with Task Force recommendations, including providing coverage of services with an 'A" or 'B" grade for the recommended population and at the recommended frequency, as she determines is appropriate considering cost-effectiveness and other criteria.	Concur	2019	Awaiting Disposition	We closely monitor the release of new and updated recommendation statements of the United States Preventive Services Task Force (USPSTF) so that we can evaluate their impact on the Medicare population and alignment with Medicare coverage policies. We attend in-person meetings of the USPSTF and participate in regularly scheduled and ad hoc calls to stay informed and ensure appropriate alignment for the Medicare population. We have been utilizing this process since we began issuing preventive services national coverage determinations approximately 10 years ago.
GAO-12-966	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should insert a self-referral flag on its Medicare Part B claims form and require providers to indicate whether the advanced imaging services for which a provider bills Medicare are self-referred or not.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
GAO-12-966	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should determine and implement a payment reduction for self-referred advanced imaging services to recognize efficiencies when the same provider refers and performs a service.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.

[GAO-12-966]	Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions	9/28/2012	In order to improve CMS's ability to identify self-referred advanced imaging services and help CMS address the increases in these services, the Administrator of CMS should determine and implement an approach to ensure the appropriateness of advanced imaging services referred by self-referring providers.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
[GAO-13-246]	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should determine the content of and publish minimum national standards for the accreditation of ADI suppliers, which could include specific qualifications for supplier personnel and requiring accrediting organization review of clinical images.	Concur	2020	In progress	Current Draft has been through 2 rounds of clearance and was in the process of a 3rd round of clearance with OSORA. It is currently on hold due to other Agency priorities. Target Date of Completion: 03/02/2020
[GAO-13-246]	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should develop an oversight framework for evaluating accrediting organization performance, which could include collecting and analyzing information on accreditation results and conducting validation audits.	Concur	2020	In progress	ACCREDITATION: “Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services” proposed rule will go back into the clearance process. We would like to wait to see if this happens before preparing the GAO closure report. Target Date of Completion: 03/02/2020

GAO-13-246	Medicare Imaging Accreditation: Establishing Minimum National Standards and an Oversight Framework Would Help Ensure Quality and Safety of Advanced Diagnostic Imaging Services	5/31/2013	To help ensure that ADI suppliers provide consistent, safe, and high-quality imaging to Medicare beneficiaries, the Administrator of CMS should develop more specific requirements for accrediting organization mid-cycle audit procedures and clarify guidance on immediate-jeopardy deficiencies to ensure consistent identification and timely correction of serious care problems for the duration of accreditation.	Concur	2020	In progress	We have not developed new Conditions of Coverage for ADI suppliers. At this time the oversight of the minimum national standards has been granted to the Accrediting Organizations. Target Date of Completion: 03/02/2020
GAO-13-287	End-Stage Renal Disease: CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment	3/1/2013	To reduce the incentive for facilities to restrict their service provision to avoid reaching the LVPA treatment threshold, the Administrator of CMS should consider revisions such as changing the LVPA to a tiered adjustment.	Concur	2022	In progress	we had extensive discussions with MedPAC regarding their suggestions for modifying the low-volume payment adjustment (LVPA). In addition, analysis of the LVPA methodology has been incorporated into the research we are doing on potential refinements to the ESRD PPS which includes opportunities to obtain stakeholder feedback.
GAO-13-384	Medicaid Demonstrations Waiver: Approval Process Raises Cost Concerns and Lacks Transparency	7/18/2013	To improve the transparency of the process for reviewing and approving spending limits for comprehensive section 1115 demonstrations, the Secretary of Health and Human Services should reconsider adjustments and costs used in setting the spending limits for the Arizona and Texas demonstrations, and make appropriate adjustments to spending limits for the remaining years of each demonstration.	Concur	2020	In progress	CMS is in the process of responding to additional questions received from GAO in October 2019.

GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should insert a self-referral flag on Medicare Part B claim forms and require providers to indicate whether the anatomic pathology services for which the provider bills Medicare are self-referred or not.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should determine and implement an approach to ensure the appropriateness of biopsy procedures performed by self-referring providers.	Non-Concur	NA	Awaiting Disposition	The CMS does not concur. GAO identified 918,000 instances of self-referral that would need to be reviewed to determine if the services were furnished in accordance with specific coverage and payment criteria with respect to when a particular biopsy should be taken or how many specimens should be reviewed by pathologists. Without review of large numbers of claims, we believe it is difficult to make recommendations regarding whether these services are appropriate.
GAO-13-445	Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer	7/15/2013	In order to improve CMS's ability to identify self-referred anatomic pathology services and help CMS avoid unnecessary increases in these services, the Administrator of CMS should develop and implement a payment approach for anatomic pathology services that would limit the financial incentives associated with referring a higher number of specimens--or anatomic pathology services--per biopsy procedure.	Concur	2019	Awaiting Disposition	The CMS plans no further action. CMS has communicated to GAO recommendation has been addressed. PFS rates are determined based upon the resources involved in furnishing a service. To the extent that the payment rates are higher than the cost of resources used in furnishing the services, an incentive may exist to provide additional services. We have looked at Current Procedural Terminology code 88305 (the most commonly furnished anatomic pathology service) as a potentially misvalued code and revalued it accordingly in calendar year 2013. As we have reduced payment for this service by approximately 30 percent, we have significantly reduced the financial incentives associated with self-referral for these procedures.

GAO-13-525	Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny	8/1/2013	The Administrator of CMS should insert a self-referral flag on its Medicare Part B claims form, require providers to indicate whether the IMRT service for which a provider bills Medicare is self-referred, and monitor the effects that self-referral has on costs and beneficiary treatment selection.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
GAO-14-362	Foster Children: Additional Federal Guidance Could Help States Better Plan for Oversight of Psychotropic Medications Administered by Managed-Care Organizations	5/22/2014	To assist states that rely on or are planning to contract with an MCO to administer Medicaid prescription benefits, and to help provide effective oversight of psychotropic medications prescribed to children in foster care, the Secretary of Health and Human Services should issue guidance to state Medicaid, child-welfare, and mental-health officials regarding prescription-drug monitoring and oversight for children in foster care receiving psychotropic medications through MCOs.	Concur	2020	In progress	CMS in progress. CMS to provide documentation of the first annual DURs.
GAO-14-571	Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use	9/2/2014	To ensure that MA encounter data are of sufficient quality for their intended purposes, the Administrator of CMS should establish specific plans and time frames for using the data for all intended purposes in addition to risk adjusting payments to MAOs.	Concur	2017	In progress	CMS has completed the tasks described in our response. Specifically, we have developed and implemented a protocol based on the EQR Protocol 4 Validation of Encounter Data as suggested. We have used various venues to communicate with MAOs about data completeness and quality and have initiated a compliance effort. We continue to assess our system and take an approach of continuous improvement to both our systems and our guidance. CMS has released the data to various entities, including the Medicare Payment Advisory Commission (MedPAC), and the Office of the Assistant Secretary for Preparedness (ASPR), which is using the data for emergency response purposes. Within the agency, we have made the data available through the CMS Integrated Data Repository (IDR) – CMS' internal data warehouse. The Center for Program Integrity (CPI) has accessed the data, as well as the Medicare Drug and Health Plan Contract Administration Group (MCAG), which plans to use the data for development of its care coordination measures. CMS is also preparing to release the data to researchers, a timeframe for release will be vetted with senior CMS leadership at the data governance board (DGB).

GAO-14-571	Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use	9/2/2014	To ensure that MA encounter data are of sufficient quality for their intended purposes, the Administrator of CMS should complete all the steps necessary to validate the data, including performing statistical analyses, reviewing medical records, and providing MAOs with summary reports on CMS's findings, before using the data to risk adjust payments or for other intended purposes.	Concur	2018	In progress	MAOs' encounter data systems are maturing, as reflected in their increased rate of data submissions each year. Likewise, CMS's Encounter Data System (EDS) is working efficiently, and is processing increasingly larger volumes of encounter data timely and accurately. The overall volume of records processed has increased an average of 12 percent annually from 2013 through 2017. To date, EDS has processed over 3 billion records. CMS has been conducting numerous ongoing analyses to assess the completeness and validity of submissions and regularly provides feedback to submitters via user group calls, on-site visits, 1-1 technical assistance, listening forums, monthly user group calls and quarterly report cards. CMS also provided a framework for encounter data compliance in the 2018 call letter, which is based on the MA encounter data integrity plan."

GAO-14-627	Medicaid Financing: States' Increased Reliance on Funds from Health Care Providers and Local Governments Warrants Improved CMS Data Collection	7/29/2014	The Administrator of CMS should develop a data collection strategy that ensures that states report accurate and complete data on all sources of funds used to finance the nonfederal share of Medicaid payments. There are short- and long-term possibilities for pursuing the data collection strategy, including (1) in the short-term, as part of its ongoing initiative to annually collect data on Medicaid payments made to hospitals, nursing facilities, and other institutional providers, CMS could collect accurate and complete facility-specific data on the sources of funds used to finance the nonfederal share of the Medicaid payments, and (2) in the long-term, as part of its ongoing initiative to develop an enhanced Medicaid claims data system (T-MSIS), CMS could ensure that T-MSIS will be capable of capturing information on all sources of funds used to finance the nonfederal share of Medicaid payments, and, once the system becomes operational, ensure that states report this information for supplemental Medicaid payments and other high risk Medicaid payments.	Non-Concur	NA	Awaiting Disposition	CMS non-concurs with this recommendation; however, will provide additional information to GAO for a new engagement related to this audit.
GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should direct CMS to establish a requirement for qualified CDRs to demonstrate improvement on key measures of quality and efficiency for their target populations.	Concur	2020	In progress	QSOG will provide response for the action requested to establish a requirement for qualified clinical data registries to demonstrate improvement on key measures of quality and efficiency for their target populations. Also to establish a requirement to demonstrate improvement. NLT November 29th, by Noon.

GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should direct CMS to establish a process for monitoring compliance with requirements for qualified CDRs that draws on relevant expert judgment. This process should assess CDR performance on each requirement in a way that takes into account the varying circumstances of CDRs and their available opportunities to promote quality and efficiency improvement for their target populations.	Concur	2020	In progress	We are providing updated links to the resources to support our reply, because the links previously provided are outdated and reflect our legacy program, PQRS. Please see below for updated links and descriptions: • In the 2019 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/168/2019%20Self-Nomination%20Resources_Updated.zip, found in the Quality Payment Program Resource Library, we include a QCDR and Qualified Registry self-nomination fact sheet that outlines the requirements and the self-nomination process. On Page 10 of the QCDR Self-Nomination Fact Sheet (Page 7 of the qualified registry self-nomination fact sheet), we outline our monitoring criteria, and consequences for those that fail to comply with our requirements (probation or possible preclusion). • On Page 12-13 of the 2019 QCDR/Qualified Registry Fact Sheet (updates based on the rule): https://qpp-cm-prod-content.s3.amazonaws.com/uploads/396/2019%20QPP%20Final%20Rule%20Updates%20for%20QCDRs_Registries.pdf, we discuss 2019 updates to our probation/preclusion policies against third party intermediaries. • On Page 3 of the 2019 Data Validation Criteria Fact Sheet: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/436/2019%20MIPS%20Data%20Validation%20Criteria.zip, we discuss data validation criteria as it pertains to QCDRs and Qualified Registries.

GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should determine and implement actions to reduce barriers to the development of qualified CDRs, such as (1) developing guidance that clarifies Health Insurance Portability and Accountability Act requirements to promote participation in qualified CDRs; (2) working with private sector entities to make relevant multipayer cost data available to qualified CDRs; (3) testing one or more models of shared savings between Medicare and qualified CDRs that achieve reduced Medicare expenditures with improved quality of care, and (4) providing technical assistance to qualified CDRs.	Concur	2020	In progress	We are providing updated links to the resources to support our reply, because the links previously provided are outdated and reflect our legacy program, PQRS. Please see below for updated links and descriptions:• In the 2019 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/168/2019%20Self-Nomination%20Resources_Updated.zip, we provide multiple resources to assist QCDR applicants with their understanding of the QCDR requirements, our approval process, and QCDR measure development. This is evident through the QCDR self-nomination fact sheet, the self-nomination user guide, the QCDR measure development handbook, and the QCDR measure development workgroup slides. We also provide applicants with a QCDR measure template, so they are aware of what information is required if they plan to self-nominate QCDR measures. • In the 2020 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip we provide multiple resources to assist QCDR applicants with their understanding of the QCDR requirements, our approval process, and QCDR measure development. This is evident through the QCDR self-nomination fact sheet, the self-nomination user guide, the QCDR measure development handbook, and the QCDR measure development workgroup slides. We also provide applicants with a QCDR measure template, so they are aware of what information is required if they plan to self-nominate QCDR measures.• In the 2020 Self-Nomination Application Demo Webinar (Description: Overview of the QCDR and Qualified Registry Self-Nomination Process for 2020) : https://youtu.be/XeqwgxvFq1k; https://qpp-cm-prod-content.s3.amazonaws.com/uploads/585/2020%20Self-Nomination%20Application%20Demo%20Webinar%20Slide%20Deck_2019%2006%2011.pdf, we provide QCDR and Qualified Registry applicants with an overview of the application process, as well as our requirements. While offering technical assistance, we also offered QCDRs and Qualified Registry applicants an opportunity to ask questions during a Q&A session. • In the 2019 QCDR Measure Workgroup Webinar Part One (Description: Overview of the Qualified Clinical Data Registry (QCDR) measure development process for the Merit-based Incentive Payment System (MIPS).) : https://youtu.be/LelUZzncgoI; https://qpp-cm-prod-content.s3.amazonaws.com/uploads/501/2019%20QCDR%20Measure%20Development%20WG_Session%201_Slides.pdf, we provide QCDR applicants with additional guidance, and provides technical assistance on developing QCDR measures. • In the 2019 QCDR Measure Workgroup Webinar Part Two

							(Description: Overview of the Qualified Clinical Data Registry (QCDR) measure development process for the Merit-based Incentive Payment System (MIPS)): https://youtu.be/YxoE4kyyqUg; https://qpp-cm-prod-content.s3.amazonaws.com/uploads/501/2019%20QCDR%20Measure%20Development%20WG_Session%201_Slides.pdf, we provide QCDR applicants with guidance on developing advanced QCDR measure structures and types.

GAO-14-75	Clinical Data Registries: HHS Could Improve Medicare Quality and Efficiency through Key Requirements and Oversight	12/16/2013	To help ensure that qualified CDRs promote improved quality and efficiency of physician care for Medicare beneficiaries, the Secretary of Health and Human Services should determine key data elements needed by qualified CDRs--such as those relevant for a required core set of measures--and direct Office of the National Coordinator for Health Information Technology and CMS to include these data elements, if feasible, in the requirements for certification of EHRs under the EHR incentive programs.	Concur	2020	In progress	We are providing updated links to the resources to support our reply, because the links previously provided are outdated and reflect our legacy program, PQRS. Please see below for updated links and descriptions: • Information on required data elements and submission methods, can be found on the developer's page of the QPP Resource Library: https://qpp.cms.gov/developers. There are a few resources that address data submission and required data elements such as the Submissions Application Programming Interface (API), XML and JSON Schemas, and the QRDA III conversion tools. • The 2019 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/168/2019%20Self-Nomination%20Resources_Updated.zip, as indicated in the Self-Nomination Fact Sheets for QCDRs and Qualified Registries, they may opt to support reporting of the Promoting Interoperability Performance Category, which would require that they support data submission on the Promoting Interoperability measures that are relate to the use of CEHRT. • The 2020 QCDR/Qualified Registry Self-Nomination Tool Kit: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/580/2020%20Self-Nomination%20Toolkit%20for%20QCDRs%20%26%20Qualified%20Registries.zip, as indicated in the Self-Nomination Fact Sheets for QCDRs and Qualified Registries, they may opt to support reporting of the Promoting Interoperability Performance Category, which would require that they support data submission on the Promoting Interoperability measures that are relate to the use of CEHRT. • The 2019 Promoting Interoperability Measure Specifications: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/343/2019%20Promoting%20Interoperability%20Measure%20Specifications.zip provide technical specifications for the Promoting Interoperability measures that QCDRs and Qualified Registries must use if they intend on reporting on these measures.

GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to organize cost and quality information in the CMS Compare websites to facilitate consumer identification of the highest-performing providers, such as by listing providers in order based on their performance.	Concur	2021	In progress	CMS is looking into defining value or performance based on these attributes is still researching the best way to do this. CMS is also exploring volume data alongside cost and quality. During CY2020 and CY2021, CMS will continue to add "meaningful" pricing and volume data where appropriate next to quality.
GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to include in the CMS Compare websites the capability for consumers to customize the information presented, to better focus on information relevant to them.	Concur	2020	In progress	Recommendations will be met when the Care Choice Experience launches in early CY2020. This digital service will provide users with the most meaningful information based on their specific needs according to our consumer research. Later in CY2020, CMS will extend functionality to be even more personalized to the user by drilling down on their health situation.
GAO-15-11	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to develop specific procedures and performance metrics to ensure that CMS's efforts to promote the development and use of its own and others' transparency tools adequately address the needs of consumers.	Concur	2020	In progress	CMS working on closure submission. CMS has integrated data-driven and user-centered design practices into the development of all web-based products, including any tools designed to promote price transparency. Each tool or product has identified Objectives & Key Results (OKRs) that describe success in terms of impact on the user and how well the product is addressing pain points in the user experience. The measurement of these (OKRs) is supported by Google Analytics, Qualtrics surveys (page level feedback and overall site satisfaction), user testing, and other available data sources. Feedback on OKR performance is shared at regular intervals with the product teams, who use that data to further improve their products and tools to better meet the needs of consumers. Performance on OKRs are also regularly reported to OC leadership and the Administrator.

GAO-15-11-1	Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers	11/18/2014	To improve consumers' access to relevant and understandable information on the cost and quality of health care services, the Secretary of HHS should direct the Administrator of CMS to include in the CMS Compare websites, to the extent feasible, estimated out-of-pocket costs for Medicare beneficiaries for common treatments that can be planned in advance.	Concur	2020	In progress	While the Procedure Price Lookup (PPL) Tool was launched in November of 2018, CMS plans to expose additional cost information throughout CY2020. For PPL, CMS will be adding physicians fees to the over out of pocket costs which will greatly improve the overall cost a Beneficiaries is expected to pay for certain procedures. PPL will also extend what is shows by beginning to expose other out-of-pocket costs for common procedures. Lastly, a new tool launching in early CY2020 known as the Care Choice Experience will provide users with what they may expect to pay for a routine doctor's visits for some types of physicians.
GAO-15-239	Medicaid Demonstrations: Approval Criteria and Documentation Need Clarity to Illuminate How Spending Furthers Medicaid Objectives	5/13/2015	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, the Secretary of Health and Human Services should issue criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives.	Concur	2019	In progress	5/7/19 - GAO requests target date for the first draft of written protocols outlining the step-by-step process for application review and preparation of approval documents for section 1115 demonstrations
GAO-15-239	Medicaid Demonstrations: Approval Criteria and Documentation Need Clarity to Illuminate How Spending Furthers Medicaid Objectives	5/13/2015	To improve the transparency and accountability of HHS's section 1115 Medicaid demonstration approval process, and to ensure that federal Medicaid funds for the demonstrations do not duplicate other federal funds, the Secretary of Health and Human Services should ensure the application of these criteria is documented in all HHS's approvals of section 1115 demonstrations, including those approving new or extending or modifying existing expenditure authorities, to inform internal and external stakeholders, including states, the public, and Congress, of the basis for the agency's determinations that approved expenditure	Concur	2019	In progress	5/7/19 - GAO requests target date for the first draft of written protocols outlining the step-by-step process for application review and preparation of approval documents for section 1115 demonstrations

			authorities are likely to promote Medicaid objectives.				
GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should take steps to ensure that states report accurate provider-specific payment data that include accurate unique national provider identifiers (NPI).	Concur	2019	In progress	We are in the process of developing guidance that is scheduled for release later this year
GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should develop a policy establishing criteria for when such payments at the provider level are economical and efficient.	Concur	2019	In progress	We are in the process of developing guidance that is scheduled for release later this year
GAO-15-322	Medicaid: CMS Oversight of Provider Payments Is Hampered by Limited Data and Unclear Policy	5/11/2015	To improve CMS's oversight of Medicaid payments, the Administrator of CMS should, once criteria are developed, develop a process for identifying and reviewing payments to individual providers in order to determine	Concur	2019	In progress	We are in the process of developing guidance that is scheduled for release later this year

			whether they are economical and efficient.				
GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should better document the process for establishing relative values for Medicare physicians' services, including the methods used to review RUC recommendations and the rationale for final relative value decisions.	Concur	2020	In progress	CMS is enhancing its process for establishing relative values for Medicare physicians' services that will allow for greater transparency and documentation, goal with the newly established process which allows the public to comment on proposed relative values in including CMS' review of RUC recommendations. Significant progress has been made towards this response to the proposed rule and the subsequent finalization of relative values in the final rule. In 2017 PFS rulemaking, the relative values for over 200 services were proposed, commented on, and successfully finalized.
GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should develop a process for informing the public of potentially misvalued services identified by the RUC, as CMS already does for potentially misvalued services identified by CMS or other stakeholders.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
GAO-15-434	Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy	5/21/2015	To help improve CMS's process for establishing relative values for Medicare physicians' services, the Administrator of CMS should incorporate data and expertise from physicians and other relevant stakeholders into the process as well as develop a timeline and plan for using the funds appropriated by the Protecting Access to Medicare Act of 2014.	Concur	2019	Awaiting Disposition	This project will fund the contract that will provide CMS with critical analyses, modeling, and data required to propose to update the GPCIs in CY 2020. This will include evaluating the current methodologies for calculating the GPCIs and considering whether to make changes to how the underlying data are analyzed in FY 2019. These changes would then be considered for potential inclusion in rulemaking during CY 2020.

GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS augment MA network adequacy criteria to address provider availability.	Concur	2020	Awaiting Disposition	Although CMS does not include provider availability in the HSD tables, CMS does require the provider directory to notate whether the provider is accepting new patients. CMS requires the provider directory to be updated within 30 days of notification of a change. CMS believes this is the appropriate place to notate it since provider availability can change. The HSD tables are submitted to CMS only when we request them, which provides a snapshot of the network at that time. Because of this aspect, the HSD tables would not provide the most current, up to date information for provider availability.
GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS verify provider information submitted by MAOs to ensure validity of the Health Services Delivery data.	Concur	2020	Awaiting Disposition	CMS currently has one method of verifying the accuracy of the data and is developing a second one. First, during CMS' online provider directory reviews, we asked MAOs if they use the same underlying database for HSD tables as they do for provider directories. Over 95% of MAOs apparently use the same underlying database for both HSD tables and provider directories. Since MAOs use the same database for both, CMS findings of inaccurate provider directories identifies errors in their HSD tables, resulting in verification of HSD tables. CMS is also looking at using the National Plan and Provider Enumeration System (NPPES) as a common source that MAOs can access for provider information. CMS' goal is to have providers update only one source, NPPES, which should result in an update to a single source of data for MAOs to use. With a single source, MAOs can download this data to utilize for their provider directory which can also be utilized for their HSD tables.
GAO-15-710	Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy	9/28/2015	To improve its oversight of network adequacy in MA, we recommend that the Administrator of CMS set minimum requirements for MAO letters notifying enrollees of provider terminations and require MAOs to submit sample letters to CMS for review.	Concur	2020	Awaiting Disposition	CMS, through 42 CFR 422.111(e), requires MAOs to notify beneficiaries of network changes (including terminations). These require that letters be provided to every beneficiary whose Primary Care Provider is leaving the network. In addition, those members who regularly see specialists must also be notified. Notification must occur at least 30 days prior to the effective termination date. Although CMS does not have specific requirements for the network change letters, CMS has seen samples of letters. These letters clearly address the provider(s) that is leaving the network and provides information on how to locate another provider, including the MAO's customer service number for assistance. CMS can look into whether formal requirements for these letters are necessary.

GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	3/7/2016	To promote consistency in the distribution of supplemental payments among states and with CMS policy, the Administrator of CMS should issue written guidance clarifying its policy that requires a link between the distribution of supplemental payments and the provision of Medicaid-covered services.	Concur	2020	In progress	CMS has issued guidance to States
GAO-16-108	Medicaid: Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments	3/7/2016	To promote consistency in the distribution of supplemental payments among states and with CMS policy, the Administrator of CMS should issue written guidance clarifying its policy that payments should not be made contingent on the availability of local funding.	Concur	2020	In progress	CMS has issued guidance to States
GAO-16-125	End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis	11/16/2015	To determine the extent to which Medicare payments are aligned with costs for specific types of dialysis treatment and training, the Administrator of CMS should take steps to improve the reliability of the cost report data for treatment and training associated with specific types of dialysis.	Concur	2020	In progress	CMS is exploring ways to improve the current cost report instructions and data collection to increase the accuracy of the information submitted.
GAO-16-125	End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis	11/16/2015	To ensure that patients with chronic kidney disease receive objective and timely education related to this condition, the Administrator of CMS should examine the Kidney Disease Education benefit and, if appropriate, seek legislation to revise the categories of providers and patients eligible for the benefit.	Non-Concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.

GAO-16-137	Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans	5/11/2016	Assess the feasibility of updating the agency's study on the effect of VA-provided Medicare-covered services on per capita country Medicare FFS spending rates by obtaining VA utilization and diagnosis data for veterans enrolled in Medicare FFS under its existing data use agreement or by other means as necessary.	Non-Concur	NA	Awaiting Disposition	The lack of improved accuracy in the MA ratebook calculation and the costs involved in obtaining and maintaining the data lead us to conclude that the recommended approach is not feasible.
GAO-16-137	Medicare Advantage: Action Needed to Ensure Appropriate Payments for Veterans and Nonveterans	5/11/2016	If CMS makes an adjustment to the benchmark to account for VA spending on Medicare-covered services, the agency should assess whether an additional adjustment to MA payments is needed to ensure that payments to MA plans are equitable for veterans and nonveterans.	Non-concur	NA	Awaiting Disposition	GAO stated that, "if CMS determines that an adjustment to the benchmark to account for VA spending is needed and the adjustment results in payments to MA plans that are too high for veterans, additional adjustments to payments to MA plans could be necessary." Currently, we do not know if the resulting benchmarks are too high or too low for veterans. Without the utilization and diagnoses data, such an assessment is not possible. In addition, we note that if CMS were to determine that such a payment adjustment were necessary, the agency would need, not just a one-time data transfer, but would also need to develop an ongoing data feed between the VA and CMS. This data feed would require an enormous system development effort for both the VA and CMS, including secure connections, data infrastructure development, increase in data storage capacity, and security certifications, which would be a resource-intensive process.
GAO-16-238	Nonemergency Medical Transportation: Updated Medical Guidance Could Help States	3/3/2016	To ensure states have appropriate and current guidance to assist them in designing and administering Medicaid NEMT, the Secretary of HHS should direct CMS to assess current Medicaid NEMT guidance and update that guidance as needed.	Concur	2020	In progress	Determining leaderships opinion regarding the desired approach to NEMT and the necessity and appropriateness of guidance.
GAO-16-265	Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls	3/23/2016	To improve the oversight of privacy and security controls over the state-based marketplaces, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to define procedures for overseeing state-based marketplaces, to include day-	Concur	2021	Awaiting Disposition	CMS submitted evidence to GAO to support closure.

			to-day activities of the relevant offices and staff.				
[GAO-16-265]	Healthcare.gov: Actions Needed to Enhance Information Security and Privacy Controls	3/23/2016	To improve the oversight of privacy and security controls over the state-based marketplaces, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to require continuous monitoring of the privacy and security controls over state-based marketplaces and the environments in which those systems operate to more quickly identify and remediate vulnerabilities.	Concur	2021	Awaiting Disposition	CMS submitted evidence to GAO to support closure.

GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to track the value of advance premium tax credit and cost-sharing reduction (CSR) subsidies that are terminated or adjusted for failure to resolve application inconsistencies, and use this information to inform assessments of program risk and performance.	Concur	2020	In progress	At this time, CMS is unable to issue new CSR regulations or make CSR payments under the Department of Justice interpretation; as such, tracking CSR subsidies is no longer a relevant recommendation due to programmatic changes. CMS plans to change its management decision to non-concur.

GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to identify and implement procedures to resolve Social Security number inconsistencies where the Marketplace is unable to verify Social Security numbers or applicants do not provide them.	Concur	2020	In progress	CMS reconsiders this recommendation CLOSED. CMS deployed modify/update SSN functionality in April 2017 that now allows resolution of a SSN.

GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to reevaluate CMS's use of Prisoner Update Processing System (PUPS) incarceration data and make a determination to either (a) use the PUPS data, among other things, as an indicator of further research required in individual cases, and to develop an effective process to clear incarceration inconsistencies or terminate coverage, or (b) if no suitable process can be identified to verify incarceration status, accept applicant attestation on status in all cases, unless the attestation is not reasonably compatible with other information that may indicate incarceration, and forego the inconsistency process.	Concur	2021	In progress	At this time CMS is accepting attestation in alignment with the GAO recommendation. We are not conducting the formal inconsistency process. It would require resources that are better spent on other Marketplace priorities to NOT set the incarceration inconsistencies at all.

[GAO-16-29]	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to create a written plan and schedule for providing Marketplace call center representatives with access to information on the current status of eligibility documents submitted to CMS's documents processing contractor.	Concur	2020	In progress	CMS believes this recommendation is CLOSED. CMS developed and implemented a tool that the call center reps can use to look up the current status of an individual when they call the marketplace. This tool is called Marketplace Consumer Record (MCR) and was implemented in 2017.

GAO-16-29	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to fully document prior to implementation, and have readily available for inspection thereafter, any significant decision on qualified health plan enrollment and eligibility matters, with such documentation to include details such as policy objectives, supporting analysis, scope, and expected costs and effects.	Concur	2020	In progress	Each year CMS publishes its Notice of Benefit and Payment Parameters (i.e., 'Payment Notice') in draft, and then in final. This regulation provides a comprehensive description of major proposed Marketplace changes that allows CMS to document prior to implementation and in a public forum, any significant decisions on qualified health plan enrollment and eligibility matters, including such information as policy objectives, supporting analysis, scope, and expected costs and impact. The draft regulation provides an opportunity for both the public and government oversight entities to review and comment on these proposals prior to the rule being issued in final.

GAO-16-29-3	Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Management Fraud Risk	2/24/2016	To better oversee the efficacy of PPACA's enrollment control process; to better monitor costs, risk, and program performance; to assist with tax compliance; to strengthen the eligibility determination process; to provide applicants with improved customer service and up-to-date information about submission of eligibility documentation; and to better document agency activities, the Secretary of Health and Human Services should direct the Acting Administrator of CMS to, in the case of CSR subsidies that are terminated or adjusted for failure to resolve application inconsistencies, consider and document, in conjunction with other agencies as relevant, whether it would be feasible to create a mechanism to recapture those costs, including whether additional statutory authority would be required to do so; and for actions determined to be feasible and reasonable, create a written plan and schedule for implementing them.	Concur	2020	In progress	The Attorney General of the United States has provided the Department of Health and Human Services and the Department of the Treasury with a legal opinion regarding CSR payments made to issuers of Qualified Health Plans. In light of that opinion, and the absence of any other appropriation that could be used to fund CSR payments, CSR payments to issuers were stopped as of October 2017. Therefore, CSR payments are currently prohibited unless and until a valid appropriation exists. At this time, CMS is unable to issue new CSR regulations or make CSR payments under the Department of Justice interpretation. As such, this is no longer a relevant recommendation due to programmatic changes.
GAO-16-33	Nursing Home Quality: CMS Should Continue to Improve Data and Oversight	11/30/2015	To improve the measurement of nursing home quality, the Administrator of CMS should establish and implement a clear plan for ongoing auditing to ensure reliability of data self-reported by nursing homes, including payroll-based staffing data and data used to calculate clinical quality measures.	Concur	2018	Awaiting Disposition	CMS considers this task complete. We commenced audit processes in February, 2018, and audits are ongoing. An example of the audit reports being received on a regular basis will be included as supporting documentation in the GAO closure statement. CMS has established a work plan for development and testing of the standardized survey process. We have several contractors working with us on the development of the software to be finalized on October 13, 2017 and rolled out on November 18, 2017, and the development of the procedure guide. Publicly available survey materials and timelines are posted on the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html The standardized survey process has been finalized and rolled out as of November 18, 2017. It is effective in all States as of November 28, 2017, concurrent

							with the implementation of Phase 2 of the Requirements for Participation. Recommend closing this item.
GAO-16-33	Nursing Home Quality: CMS Should Continue to Improve Data and Oversight	11/30/2015	To help ensure modifications of CMS's oversight activities do not adversely affect the agency's ability to assess nursing home quality and that effective modifications are adopted more widely, the Administrator of CMS should establish a process for monitoring modifications of essential oversight activities made at the CMS central office, CMS regional office, and state survey agency levels to better understand the effects on nursing home quality oversight.	Concur	2020	In progress	We are currently implementing the new FOSS process as a National pilot. We have focused on three primary areas of focus: admission, transfer, discharge; abuse and Neglect, and Dementia care to test the survey process. We plan to implement the process fully in FY19
GAO-16-394	Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data	5/13/2016	In order to better ensure proper Medicare payments and protect Medicare funds, CMS should seek legislative authority to allow the RAs to conduct prepayment claim reviews.	Non-Concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

GAO-16-53	Medicaid: Additional Efforts Needed to Ensure that State Spending is Appropriately Matched with Federal Funds	10/23/2015	To improve the effectiveness of its oversight of eligibility determinations, the Administrator of CMS should conduct reviews of federal Medicaid eligibility determinations to ascertain the accuracy of these determinations and institute corrective action plans where necessary.	Concur	2021	In progress	Results for the first cycle of states under review will be reported in November 2019. The first cycle of the revised PERM program included two states where there were federal eligibility determinations, but no FFE samples were selected for PERM review.
GAO-16-568	Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs	8/1/2016	To ensure efficient use of federal resources, the Administrator of CMS should account for Medicaid payments a hospital has received that offset uncompensated care costs when determining hospital uncompensated care costs for the purposes of making Medicare UC payments to individual hospitals.	Concur	2021	In progress	The total aggregate Medicare uncompensated care payments available are primarily determined according to a methodology prescribed in statute. HHS has proposed to begin to use the uncompensated care data reported by hospitals in a relative sense to distribute the available aggregate amount available for uncompensated care payments. Because the compensated care data reported by hospitals is only used in a relative sense, it is not clear that it would be appropriate to offset the Medicare uncompensated care payments by the Medicaid uncompensated care payment.
GAO-16-594	Medicare Part B: CMS Should Take Additional Steps to Verify Accuracy of Data Used to Set Payment Rates for Drugs	8/1/2016	CMS should periodically verify the sales price data submitted by a sample of drug manufacturers by requesting source documentation from manufacturers to corroborate the reported data, either directly or by working with the HHS Office of Inspector General as necessary.	Concur	2019	Awaiting Disposition	CMS current activities include routine quality checks on all ASP data that is used for each quarter's pricing files. The checks include a comparison of price changes across quarters, a comparison against current WAC and a comparison against AMP (done by the OIG). These activities verify the underlying accuracy of the manufactures' data by directly comparing ASPs to other pricing indicators. Findings from these activities are used to identify situations where a referral to OIG for potential misreporting is warranted (if a direct inquiry to the manufacturer does not resolve CMS' concerns).
GAO-16-700	Skilled Nursing Facilities: CMS Should Improve Accessibility and Reliability of Expenditure Data	10/6/2016	To improve the accessibility and reliability of SNF expenditure data, the Acting Administrator of CMS should take steps to improve the accessibility of SNF expenditure data, making it easier for public stakeholders to locate and use the data.	Concur	2019	Awaiting Disposition	CMS currently posts raw SNF expenditure data on the CMS website, where it is available for public stakeholders to view and use. This complies with HHS' legislative requirement to make information on SNFs' expenditures "readily available to interested parties upon request." CMS has determined the costs to the program of reformatting this data to implement GAO's recommendation would outweigh the benefits of doing so. This effort would be a significant burden upon staff, and HHS has not received requests from public stakeholders to make the data more readily accessible. We consider this recommendation closed – not implemented.

GAO-16-700	Skilled Nursing Facilities: CMS Should Improve Accessibility and Reliability of Expenditure Data	10/6/2016	To improve the accessibility and reliability of SNF expenditure data, the Acting Administrator of CMS should take steps to ensure the accuracy and completeness of SNF expenditure data.	Non-Concur	NA	Awaiting Disposition	CMS position of non concurring has not changed. CMS collects SNF expenditure data in cost reports for general information purposes. HHS takes a risk-based approach to determining priorities and allocation of resources. The amount of time and resources that may be required to verify the accuracy and completeness of SNF expenditure data could be substantial, without the potential of creating a significant benefit to the agency or the public.
GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments and to improve the accuracy of CMS's calculation of coding intensity, the Administrator should modify that calculation by taking actions such as the following: (1) including only the three most recent pair-years of risk score data for all contracts; (2) standardizing the changes in disease risk scores to account for the expected increase in risk scores for all MA contracts; (3) developing a method of accounting for diagnostic errors not coded by providers, such as requiring that diagnoses added by MA organizations be flagged as supplemental diagnoses in the agency's Encounter Data System to separately calculate coding intensity scores related only to diagnoses that were added through MA organizations' supplemental record review (that is, were not coded by providers); and (4) including MA beneficiaries enrolled in contracts that were renewed from a different contract under the same MA organization during the pair-year period.	Concur	2020	In progress	CMS is exploring various options to improve accuracy of coding intensity calculations, as well as possible alternatives to coding intensity for selecting contracts for RADV. We anticipate implementing these changes for future RADV audits.

GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS’s Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should modify CMS's selection of contracts for contract-level RADV audits to focus on those contracts most likely to have high rates of improper payments by taking actions such as the following: (1) selecting more contracts with the highest coding intensity scores; (2) excluding contracts with low coding intensity scores; (3) selecting contracts with high rates of unsupported diagnoses in prior contract-level RADV audits; (4) if a contract with a high rate of unsupported diagnoses is no longer in operation, selecting a contract under the same MA organization that includes the service area of the prior contract; and (5) selecting some contracts with high enrollment that also have either high rates of unsupported diagnoses in prior contract-level RADV audits or high coding intensity scores.	Concur	2020	In progress	The initial Contract-Level RADV audit design was based on a limited set of payment error data available at that time. As part of an effort to improve the audits, CMS is reevaluating the audit design to ensure its rigor in the context of all the payment error data acquired since the original design, including an examination of whether coding intensity is the best criteria by which to select contracts for audit. Addressing this recommendation does help determine the full extent to which improper payments occur and reasonably assure that appropriate actions are taken to reduce them.

GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should enhance the timeliness of CMS's contract-level RADV process by taking actions such as the following: (1) closely aligning the time frames in CMS's contract-level RADV audits with those of the national RADV audits the agency uses to estimate the MA improper payment rate; (2) reducing the time between notifying MA organizations of contract audit selection and notifying them about the beneficiaries and diagnoses that will be audited; (3) improving the reliability and performance of the agency's process for transferring medical records from MA organizations, including assessing the feasibility of updating Electronic Submission of Medical Documentation for use in transferring medical records in contract-level RADV audits; and (4) requiring that CMS contract-level RADV auditors complete their medical record reviews within a specific number of days comparable to other medical record review time frames in the Medicare program.	Concur	2020	In progress	Whenever feasible, CMS aligns the initiation of RADV contract-level audits with RADV national audits. CMS is actively working toward reducing the time between initially notifying a plan and the distribution of sample details to the time allowed for a plan to credential users in the Central Data Abstraction Tool (CDAT) audit system. CMS also has begun the process of modernizing CDAT to improve system performance and reliability, initiated a project to explore direct ingestion of electronic medical record documentation, and convened a panel to collect industry best practices in the review of electronic medical records.

GAO-16-76	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should improve the timeliness of CMS's contract-level RADV appeal process by requiring that reconsideration decisions be rendered within a specified number of days comparable to other medical record review and first-level appeal time frames in the Medicare program.	Concur	2020	In progress	CMS is actively considering options for expediting the appeals process. Addressing this recommendation does not help determine the full extent to which improper payments occur and reasonably assure that appropriate actions are taken to reduce them. The focus of this recommendation is on the administrative efficiency and timeliness of the CMS Appeals process, not the recovery directly.
GAO-16-76-5	Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments	5/9/2016	As CMS continues to implement and refine the contract-level RADV audit process to improve the efficiency and effectiveness of reducing and recovering improper payments. The Administrator should ensure that CMS develops specific plans and a timetable for incorporating a RAC in the MA program as mandated by the Patient Protection and Affordable Care Act.	Concur	2020	In progress	CMS believes that the functions of a Part C RAC are currently being performed by the Risk Adjustment Data Validation (RADV) program. The proposed scope of the Part C RAC has been subsumed by RADV and CMS will demonstrate that the RADV program satisfies Part C RAC recommendations found in GAO 16-76.
GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports	2/8/2017	To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS require all states to collect and report on progress towards achieving MLTSS program goals, such as whether the program enhances the provision of community-based care.	Concur	2020	In progress	Develop additional guidance beyond scorecard measures for use in reporting on MLTSS goals
GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment	2/8/2017	To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS establish criteria for what situations would warrant exceptions to the federal	Concur	2020	In progress	Develop additional guidance beyond scorecard measures for use in reporting on MLTSS goals

	Rates for Long-Term Services and Supports		standards that the data used to set rates be no older than the 3 most recent and complete years.				
GAO-17-145	Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports	2/8/2017	To improve oversight of states' payment structures for MLTSS, we recommend that the Administrator of CMS provide states with guidance that includes minimum standards for encounter data validation procedures.	Concur	2020	In progress	Once finalized, CMS intends to publish guidance to states on reporting consistent with 438.66.
GAO-17-169	Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services	2/13/2017	To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of and spending on Medicaid personal care services, CMS should develop plans for analyzing and using personal care services data for program management and oversight.	Concur	2019	Awaiting Disposition	CMCS has not identified a need to establish these standards as we received no questions from states on this nor have states been out of compliance when reviewing rate setting documentation submitted since 7/1/2017
GAO-17-169	Medicaid: CMS Needs Better Data to Monitor the Provision of and Spending on Personal Care Services	2/13/2017	To improve the collection of complete and consistent personal care services data and better ensure CMS can effectively monitor the states' provision of and spending on Medicaid personal care services, CMS should better ensure that personal care services data collected from states through T-MSIS and MBES comply with CMS reporting requirements.	Concur	2020	In progress	Once finalized, CMS intends to publish guidance to states on reporting consistent with 438.66.

GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that state-based marketplace annual sustainability plans, to the extent possible, have complete 5-year budget forecasts.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation, no planned actions
GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that all state-based marketplaces provide required annual financial audit reports which are in accordance with generally accepted government auditing standards.	Concur	2017	In progress	CMS has taken specific actions to assist each State Based Exchange (SBE) in completing and submitting its annual financial and programmatic audits. Although not IT-focused, as described in the OIG report, CMS utilizes these audits to obtain visibility into Exchanges to assess their financial health and/or compliance with CMS regulations. CMS implemented steps to ensure that SBEs had clear guidance on the audit requirements.
GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that marketplace IT self-sustainability risk assessments are based on fully defined measurable terms, a clear categorization process, and a defined response to high risks.	Concur	2017	In progress	Per the ACA, a state operating a State-based Exchange must ensure that it is self-sustaining beginning on January 1, 2015 when the grant funding was no longer available. As a result, CMS focused its oversight efforts on assessing an Exchange's self-sustainability through a broad range of factors, including revenue source, issuer landscape, remaining grant funding, and staffing.
GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that states develop, update, and follow performance measurement plans that allow the states to continuously identify and assess the most important IT metrics for their state marketplaces.	Non-Concur	2017	In Progress	CMS partially concurs with this recommendation. We believe each marketplace is individually accountable, but we will provide guidance to support.

GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to conduct operational analysis reviews and systematically monitor the performance of states' marketplace IT systems using key performance indicators.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation, no planned actions
GAO-17-258	Health Insurance Marketplaces: CMS Needs to Improve its Oversight of State IT Systems' Sustainability and Performance	9/12/2017	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to take steps to ensure that metrics collected from states to monitor marketplaces' operational performance link to performance goals and include baselines and targets to monitor progress.	Non-Concur	NA	Awaiting Disposition	CMS does not concur with this recommendation, no planned actions
GAO-17-28	Medicaid Personal Care Services: CMS Could Do More to Harmonize Requirements across Programs	12/22/2016	To achieve a better understanding of the effect of certain PCS services on beneficiaries and a more consistent administration of policies and procedures across PCS programs, we recommend the Acting Administrator of CMS collect and analyze states' required information on the impact of the Participant-Directed Option and Community First Choice programs on the health and welfare of beneficiaries as well as the state quality measures for the Participant-Directed Option and Community First Choice programs.	Concur	2020	In progress	Policy development is in progress

GAO-17-312	Medicaid Demonstrations: Federal Action Needed to Improve Oversight of Spending	5/3/2017	To improve consistency in CMS oversight of federal spending under section 1115 demonstrations, the Secretary of Health and Human Services should require the Administrator of CMS to develop and document standard operating procedures for monitoring spending under demonstrations that (1) require setting reporting requirements for states that provide CMS the data elements needed for CMS to assess compliance with demonstration spending limits; (2) require consistent enforcement of states' compliance with financial reporting requirements; and (3) require consistent tracking of the amount of unspent funds under demonstration spending limits.	Concur	2020	In progress	SOPs and the budget neutrality tool are currently being tested, and have not been finalized.
GAO-17-42	Medicare: Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures	12/15/2016	To improve the efficiency and effectiveness of the agency's enrollment screening process, the Administrator of CMS should establish objectives and performance measures for assessing progress toward achieving its goals.	Concur	2020	Awaiting Disposition	CMS submitted closure evidence.
GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to annually report improper payment estimates and error rates for the advance PTC program.	Concur	2021	In progress	CMS is in the process of developing an improper payment measurement for the advance premium tax credit (PTC). The development of the measurement methodologies will be a multi-year process which consists of the development of measurement policies, procedures, and tools. It also includes extensive pilot testing to ensure an accurate and efficient improper payment estimate, as well as, acquisition activities for procurement of improper payment measurement contractors

GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, and until annual reporting of improper payment estimates and error rates for the advance PTC program is performed, the Secretary of Health and Human Services should direct the Administrator of CMS to disclose significant matters relating to the Improper Payments Information Act (IPIA) estimation, compliance, and reporting objectives for the advance PTC program in the agency financial report, including CMS's progress and timeline for expediting the achievement of those objectives and the basis for any delays in meeting IPIA requirements.	Concur	2021	In progress	CMS continue to update its annual AFRs on the status of the measurement program development until the improper payment estimate is reported.
GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to design and implement procedures for verifying the identities of phone and mail applicants to reasonably assure that ineligible individuals are not enrolled in qualified health plans in the marketplaces or provided advance PTC.	Concur	2020	In progress	CMS is continuing to explore alternatives for assessing risk and ensuring integrity of applicant information that is provided to the program and ways to ensure personal information provided by a consumer is accurate through a variety of means. After this analysis phase, CMS will assess resource requirements, cost and operational implications for potential implementation approaches.

GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to assess and document the feasibility and availability of obtaining sufficiently reliable data to verify individuals' residencies and lack of minimum essential coverage from nonfederal employers and, if appropriate, design and implement procedures for using such data in its verification processes.	Concur	2020	In progress	CMS assessed the feasibility of residency verification and have determined it is not feasible. Paper on our analysis is attached. We will not take further action on this recommendation and believe it should be closed at this time. We expect to provide an update on the ESC MEC issue in the near future.
GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to assess and document the feasibility of approaches for (1) identifying duplicate government-sponsored coverage for individuals receiving Medicaid and Children's Health Insurance Program coverage in federally facilitated marketplace states outside of the states where they attest to residing and (2) periodically verifying individuals' continued eligibility by working with other government agencies to identify changes in life circumstances that affect advance PTC9 eligibility--such as commencement of duplicate coverage or deaths-- that may occur during the plan year and, if appropriate, design and	Concur	2022	In progress	CMS designed a process that will address the second part of this recommendation and documented that in the attached paper. We are still working to address the first part of this recommendation.

			implement these verification processes.				
GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/14/2017	To improve annual reporting on PTC improper payments, control activities related to eligibility determinations, and calculations of advance PTC, the Secretary of Health and Human Services should direct the Administrator of CMS to assess and document the feasibility of approaches for terminating advance PTC on a timelier basis and, as appropriate, design and implement procedures for improving the timeliness of terminations.	Concur	2021	In progress	CMS determined our approach to terminating APTC. We have included in our 3 year work plan for implementation and will provide an actual data once we have one scheduled. We have provided GAO with a document that outlines our planned approach.

GAO-17-467	Improper Payments: Improvements Needed in CMS and IRS Controls over Health Insurance Premium Tax Credit	7/13/2017	Design and implement procedures for verifying compliance with applicable tax filing requirements, including the filing of the federal tax return and the Form 8962, Premium Tax Credit, necessary for individuals to continue to be eligible for APTC.	Concur	2019	Awaiting Disposition	Closed implemented 10/02/19.
GAO-17-5	Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures	10/13/2016	To make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, the Secretary of HHS should direct CMS to comprehensively plan, including setting timelines, for how to target its development of new, more meaningful quality measures on those that will promote greater alignment, especially measures to strengthen the core measure sets that CMS and private payers have agreed to use.	Concur	2020	In progress	CMS works to provide technical support to the Core Quality Measures Collaborative (CQMC) which includes CMS collaboration with private payers is currently in Option Year One of the task order with a performance period of 9/14/2019 through 9/13/2020. The Statement of Work for this CQMC task order includes a goal "To achieve widespread adoption of parsimonious CQMC measure sets, diverse constituencies must collaborate to find opportunities for alignment, identify critical gaps, and support the adoption of aligned measure sets. With this, the CQMC aims at providing direction to align industry efforts (e.g. harnessing new, efficient data sources)." The activities planned out within the project period include finalizing measure selection criteria for new and existing core sets, approaches for prioritization of new core sets, analysis of gap areas and variation of measure specifications, and the creation of 1-2 new core measure sets. This is more complicated. We have the plans, but much depends on funding and other factors as to how quickly key elements can be implemented. We expect that by end of 2020 we will have made substantive progress on aligning measures with VA/DOD and AHIP, but it would be VERY difficult to be more specific at this holistic high level.
GAO-17-551	Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses	6/30/2017	To ensure that the HVBP program accomplishes its goal to balance quality and efficiency and to ensure that it minimizes the payment of bonuses to hospitals with lower quality scores, the Administrator of CMS should revise the formula for the calculation of hospitals' total performance score or take other actions so that the efficiency score does not have a disproportionate effect on the total performance score.	Concur	2019	Awaiting Disposition	HHS examined alternatives and considered revising the formula for the calculation of hospitals' TPS consistent with relevant statutory guidance, and in a way to reduce the effect of the efficiency domain on the TPS. Any change to the domain weighting would have to be analyzed for potential negative impact. We solicited stakeholder feedback in the FY 2019 IPPS rule, and did not finalize a weighting revision that would reduce paying bonuses to hospitals with lower quality scores. Stakeholders were concerned about the safety domain removal, and adverse impact to rural and smaller hospitals due to increasing outcome measure relative weights. In Fall 2018, CMS analyzed current data and found a similar trend, where rural and small hospitals' payment would be adversely impacted from increasing outcome measure weights. CMS decided to keep measure weights at the current 4 domain and 25% per domain weights to avoid adversely impacting rural and small hospitals

GAO-17-551	Hospital Value-Based Purchasing: CMS Should Take Steps to Ensure Lower Quality Hospitals Do Not Qualify for Bonuses	6/30/2017	To ensure that the HVBP program accomplishes its goal to balance quality and efficiency and to ensure that it minimizes the payment of bonuses to hospitals with lower quality scores, the Administrator of CMS should revise the practice of proportional redistribution used to correct for missing domain scores so that it no longer facilitates the awarding of bonuses to hospitals with lower quality scores.	Concur	2019	Awaiting Disposition	HHS is examined alternatives and considering revising the practice of proportional redistribution used to correct for missing domain scores while also being mindful of any potential unintended consequences. Any change to the distribution of weight for missing domains would have to be analyzed for potential negative impact. We solicited stakeholder feedback in the FY 2019 IPPS rule. CMS proposed to remove the safety domain and, in connection, to require scores for the remaining three domains in order to calculate the TPS. We did not finalize the weighting revision that would reduce paying bonuses to hospitals with lower quality scores. Stakeholders were concerned about the safety domain removal, and adverse impact to rural and smaller hospitals due to increasing outcome measure relative weights. In Fall 2018, CMS analyzed current data and found a similar trend, where rural and small hospitals' payment would be adversely impacted from changing proportional redistribution to assign greater relative weight to outcomes. CMS decided to keep proportional redistribution and measure weights at the current 4 domain and 25% per domain weights to avoid adversely impact rural and small hospitals.
GAO-17-600	Medicare: CMS Should Evaluate Providing Coverage for Disposable Medical Devices That Could Substitute for Durable Medical Equipment	7/17/2017	The Administrator of CMS should evaluate the possible costs and savings of using disposable devices that could potentially substitute for DME, including options for benefit categories and payment methodologies that could be used to cover these substitutes, and, if appropriate, seek legislative authority to cover these devices.	Non-Concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
GAO-17-61	Nursing Homes: Consumers Could Benefit from Improvements to the Nursing Home Compare Website and Five-Star Quality Rating System	11/18/2016	To help improve the Five-Star System's ability to enable consumers to understand nursing home quality and make distinctions between high- and low- performing homes, the Administrator of CMS should add information to the Five-Star System that allows consumers to compare nursing homes nationally.	Non-Concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any action.

GAO-17-632	Medicaid Managed Care: CMS Should Improve Oversight of Access and Quality in States' Long-Term Services and Supports Programs	9/13/2017	To improve CMS's oversight of states' MLTSS programs, the Administrator of CMS should take steps to identify and obtain key information needed to oversee states' efforts to monitor beneficiary access to quality services, including, at a minimum, obtaining information specific to network adequacy, critical incidents, and appeals and grievances.	Concur	2020	In progress	Development of guidance related to reporting on key information needed to oversee efforts related to beneficiary access to care
GAO-18-103	Medicaid: CMS Should Take Additional Steps to Improve Assessments of Individuals' Needs for Home- and Community-Based Services	1/16/2018	The Administrator of CMS should ensure that all types of Medicaid HCBS programs have requirements for states to avoid or mitigate potential conflicts of interest on the part of entities that conduct needs assessments that are used to determine eligibility for HCBS and to develop HCBS plans of service. These requirements should address both service providers and managed care plans conducting such assessments.	Concur	2020	In progress	National Training Session at NASUAD 2018 HCBS Conference process updates in progress.
GAO-18-15	Prescription Opioids: Medicare Needs to Expand Oversight Efforts to Reduce the Risk of Harm	11/6/2017	The Administrator of CMS should require plan sponsors to report to CMS on investigations and other actions taken related to providers who prescribe high amounts of opioids.	Non-concur	NA	Awaiting Disposition	CMS Non-concurs with the recommendation language.
GAO-18-179	Information Technology: Pharmacy System Needs Additional Capabilities for Viewing, Exchanging, and Using Data to Better Service Veterans	6/14/2017	The Administrator of CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred.	Concur	2020	In progress	Sub-regulatory guidance for GAO-18-179 pertaining to health and welfare is expected by the close of the calendar year

GAO-18-179	Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed	2/5/2018	The Administrator of CMS should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using home and community-based services (HCBS) waivers are required to report on their annual reports.	Concur	2020	In progress	Sub-regulatory guidance for GAO-18-179 pertaining to health and welfare is expected by the close of the calendar year
GAO-18-179	Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare Is Needed	2/5/2018	The Administrator of CMS should ensure that all states submit annual reports for HCBS waivers on time as required.	Concur	2020	In progress	Sub-regulatory guidance for GAO-18-179 pertaining to health and welfare is expected by the close of the calendar year
GAO-18-210	Electronic Health Information: CMS Oversight of Medicare Beneficiary Data Security Needs Improvement	4/5/2018	The Administrator of the Centers for Medicare and Medicaid Services should develop and distribute guidance for researchers defining minimum security controls and implementation guidance for those controls that is consistent with the National Institute of Standards and Technology guidance.	Concur	2020	In progress	CMS to develop an implementation plan based on the contractor's recommendation report.
GAO-18-210	Electronic Health Information: CMS Oversight of Medicare Beneficiary Data Security Needs Improvement	4/5/2018	The Administrator of the Centers for Medicare and Medicaid Services should develop processes and procedures to ensure that qualified entities and researchers have implemented information security controls effectively throughout their agreements with CMS.	Concur	2020	In progress	CMS to develop an implementation plan based on the contractor's recommendation report.

GAO-18-220	Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures	2/20/2018	The Administrator of CMS should establish written procedures for implementing the agency's policy that requires all states to submit a final evaluation report after the end of each demonstration cycle, regardless of renewal status.	Concur	2020	In progress	Completion in progress to meet parameters of the recommendation
GAO-18-220	Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures	2/20/2018	The Administrator of CMS should issue written criteria for when CMS will allow limited evaluation of a demonstration or a portion of a demonstration, including defining conditions, such as what it means for a demonstration to be longstanding or noncomplex, as applicable.	Concur	2020	In progress	CMS is piloting a written procedure for the clearance of federal evaluation reports.
GAO-18-220	Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures	2/20/2018	The Administrator of CMS should establish and implement a policy for publicly releasing findings from federal evaluations of demonstrations, including findings from rapid cycle, interim, and final reports; and this policy should include standards for timely release.	Concur	2021	In progress	HHS is in the process of refining and testing criteria for when CMS will allow modified evaluation requirements for a demonstration.
GAO-18-269	Federal Health Insurance Exchange: CMS Needs to Ensure Complete, Accurate Data on Terminations of Coverage for Nonpayment of Premiums	4/9/2018	The Administrator of CMS should ensure that CMS has complete data on terminations of enrollee coverage for nonpayment of premiums by requiring issuers to report these data.	Concur	2022	In progress	CMS is targeting collecting complete data via reconciliation by January 2020, which will cover 100% of policies. We will monitor data and work with issuers on compliance to ensure accurate data in the FFE by January 2021. An LOE for the IT build has been developed and awaiting approval. Implementation timeframe may be delayed and is contingent of approval of the IT build.

GAO-18-269	Federal Health Insurance Exchange: CMS Needs to Ensure Complete, Accurate Data on Terminations of Coverage for Nonpayment of Premiums	4/9/2018	The Administrator of CMS should provide a transparent process for issuers and CMS to systematically reconcile discrepancies in their data on terminations of enrollee coverage for nonpayment of premiums.	Concur	2022	In progress	CMS is targeting collecting complete data via reconciliation by January 2020, which will cover 100% of policies. We will monitor data and work with issuers on compliance to ensure accurate data in the FFE by January 2021. An LOE for the IT build has been developed and awaiting approval. Implementation timeframe may be delayed and is contingent of approval of the IT build.
GAO-18-291	Medicaid: CMS Needs to Better Measure Program Risks in Managed Care	6/6/2018	The Administrator of CMS should consider and take steps to mitigate the program risks that are not measured in the PERM, such as overpayments and unallowable costs; such an effort could include actions such as revising the PERM methodology or focusing additional audit resources on managed care.	Concur	2020	In progress	CMS is developing a strategy to reduce risk in Medicaid Managed Care.
GAO-18-341	Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending	5/21/2018	The Administrator of CMS should subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization.	Concur	2020	In progress	CMS will explore available options to subject accessories essential to the group 3 power wheelchairs in the permanent DMEPOS program to prior authorization.
GAO-18-341	Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending	5/21/2018	The Administrator of CMS should take steps, based on results from evaluations, to continue prior authorization. These steps could include: (1) resuming the paused home health services demonstration; (2) extending current demonstrations; or, (3) identifying new opportunities for expanding prior authorization to additional items and services with high unnecessary utilization and high improper payment rates.	Concur	2020	In progress	CMS has revised the home health services demonstration to include choices and flexibilities for HHAs to demonstrate their compliance with Medicare rules. Reviews have begun for IL HHA claims with dates of service on or after 6/1/19 and for OH claims with dates of service on or after 9/30/19. CMS plans to phase in three more states (Texas, North Carolina, and Florida) with at least 60 days' notice between each state.

GAO-18-528	Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks	7/26/2018	The Administrator of CMS should expedite the planned efforts to communicate guidance, such as its compendium on Medicaid managed care program integrity, to state stakeholders related to Medicaid managed care program integrity.	Concur	2020	In progress	The MPEC addresses managed care provider enrollment requirements under 42 CFR § 438.602(b)(1). The MPEC was updated summer 2018 to complete Phase I of the release of Medicaid managed care guidance. Under Phase II, CPI/GMG will release additional managed care manual guidance to address additional PI provisions under 42 CFR Part 438. The purpose of the guidance is to assist states in their efforts to comply with managed care PI provisions under 42 CFR Part 438.
GAO-18-528	Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks	7/26/2018	The Administrator of CMS should eliminate impediments to collaborative audits in managed care conducted by audit contractors and states, by ensuring that managed care audits are conducted regardless of which entity--the state or the managed care organization--recoups any identified overpayments.	Concur	2019	Awaiting Disposition	CMS believes that we have taken the necessary action, to the extent possible - to eliminate impediments to collaborative audits in managed care. As evidenced by a July 2019 meeting at the Medicaid Integrity Institute (MII), CMS, CMS's Unified Program Integrity Contractors (UPIC's) and States all gathered to discuss coordination of managed care provider investigations and how to generate actionable outcomes.
GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	The Administrator of CMS should complete a comprehensive, national risk assessment and take steps, as needed, to assure that resources to oversee expenditures reported by states are adequate and allocated based on areas of highest risk.	Concur	2020	In progress	CMS is continuing to look at the Medicaid Expenditure oversight procedures that are currently in place to assist in ensuring that resources are allocated properly.
GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	The Administrator of CMS should clarify in internal guidance when a variance analysis on expenditures with higher match rates is required.	Concur	2020	In progress	Issuance of internal guidance is in development.
GAO-18-564	Medicaid: CMS Needs to Better Target Risks to Improve Oversight of Expenditures	9/5/2018	The Administrator of CMS should revise the sampling methodology for reviewing expenditures for the Medicaid expansion population to better target reviews to areas of high risk.	Concur	2020	Awaiting Disposition	CMS has determined that, given current resources, our sampling methodology for reviewing Medicaid expansion expenditures is sufficient.

GAO-18-565	Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance	8/23/2018	The Secretary of HHS should ensure that the approach and data it uses for determining navigator award amounts accurately and appropriately reflect navigator organization performance, for example, by 1. providing clear guidance to navigator organizations on performance goals and other information they must report to HHS that will affect their future awards, 2. ensuring that the fields used to capture the information are functioning properly, and 3. assessing the effect of its current approach to funding navigator organizations to ensure that it is consistent with the agency's objectives.	Concur	2021	Awaiting Disposition	Closure documentation submitted.
GAO-18-565	Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance	8/23/2018	The Secretary of HHS should establish numeric enrollment targets for healthcare.gov, to ensure it can monitor its performance with respect to its objectives.	Non-Concur	NA	Awaiting Disposition	CMS maintains its non-concur position
GAO-18-565	Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance	8/23/2018	Should the agency continue to focus on enhancing the consumer experience as a goal for the program, the Secretary of HHS should assess other aspects of the consumer experience, such as those it previously identified as key, to ensure it has quality information to achieve its goal.	Concur	2020	In progress	HHS previously assessed the consumer experience through the availability of the two largest customer channels supporting exchange operations – the call center and Healthcare.gov – as well as customer satisfaction surveys. HHS believes these metrics represent a comprehensive assessment of the consumer experience. HHS is always looking for ways to improve the consumer experience and will consider focusing on other aspects of the consumer experience as needed.

GAO-18-70	Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight	1/8/2018	The Administrator of CMS, in partnership with the states, should take additional steps to expedite the use of T-MSIS data for program oversight. Such steps should include, but are not limited to, efforts to (1) obtain complete information from all states on unreported T-MSISdata elements and their plans to report applicable data elements; (2) identify and share information across states on known T-MSIS data limitations to improve data comparability; and (3) implement mechanisms, such as the Learning Collaborative, by which states can collaborate on an ongoing basis to improve the completeness, comparability, and utility of T-MSIS data.	Concur	2020	In progress	Review of additional GAO questions are in process.
GAO-18-70	Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight	1/8/2018	The Administrator of CMS should articulate a specific plan and associated time frames for using T-MSIS data for oversight.	Concur	2020	In progress	Review of additional GAO questions are in process.
GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework	12/5/2017	The Administrator of CMS should provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis.	Concur	2020	In progress	Fraud-awareness training for new hires began in summer 2019 on an ongoing basis. Training for all existing employees is being developed and estimated to begin early Fall 2019.

GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework	12/5/2017	The Administrator of CMS should conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk profiles and plans for regularly updating the assessments and profiles.	Concur	2020	In progress	CMS is currently conducting fraud risk assessments on various CMS programs utilizing an Enterprise Program Risk Management approach that incorporates the tenets of the GAO Fraud Risk Framework. This approach enables CMS to proactively identify potential and existing vulnerabilities in CMS programs and identify measurable, strategic solutions to mitigate these risks on a regular basis. Examples of programs under review include the Medicare Diabetes Prevention program, the Quality Payment Program, home health requests for anticipated payment, and opioid treatment programs.
GAO-18-88	Medicare and Medicaid: CMS Needs to Fully Align Its Efforts with Fraud Risk Framework	12/5/2017	The Administrator of CMS should, using the results of the fraud risk assessments for Medicare and Medicaid, create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for monitoring and evaluation.	Concur	2020	In progress	CMS is currently conducting fraud risk assessments on various Medicare related programs utilizing an Enterprise Program Risk Management approach which incorporates the tenets of the GAO Fraud Risk Framework. This approach enables CMS to examine existing vulnerabilities, identify measurable strategic solutions to reduce program risk as well as utilizing proactive approaches to reviewing new programs to reduce risk and impact to both the beneficiaries and the trust funds. Some of these programs under review include the Medicare Diabetes Prevention program, the Quality Payment Program, and CPAP machines. The Medicare Diabetes Prevention Program anti-fraud strategy is currently being developed.
A-01-14-00001	Connecticut Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Chronic Mental Illness	8/7/2015	We recommend that the State agency improve controls used to detect and prevent duplicate payments.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response
A-01-14-00001	Connecticut Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals	8/7/2015	We recommend that the State agency establish controls to ensure that the payment rate methodology used to claim Medicaid reimbursement for TCM services is in accordance with Federal and State requirements.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response

	With Chronic Mental Illness						
A-01-14-00001	Connecticut Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Chronic Mental Illness	8/7/2015	We recommend that the State agency adjust future payment rates for TCM services and work with CMS to determine the unallowable Medicaid payments that should be refunded to the Federal Government.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response
A-01-14-00002	Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	5/25/2016	We recommend that the State agency work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of abuse or neglect.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response
A-01-14-00002	Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	5/25/2016	We recommend that the State agency work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response

A-01-14-00002	Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	5/25/2016	We recommend that the State agency coordinate with DDS and OPA to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response
A-01-14-00002	Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	5/25/2016	We recommend that the State agency work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in Connecticut's MMIS to detect unreported and unrecorded critical incidents.	Concur	2020	In Progress	CMS has requested an update from the State, but has not received a response
A-01-14-02503	Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace	3/26/2015	We recommend that the State agency refund $15.9 million to CMS that was misallocated to the establishment grants by not prospectively using updated actual enrollment data.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-14-02503	Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace	3/26/2015	We recommend that the State agency refund $12.5 million to CMS that was misallocated to the establishment grants using a methodology that included a material defect.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-14-02503	Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace	3/26/2015	We recommend that the State agency immediately amend the CAP and the APD for the period July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-01-14-02503	Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace	3/26/2015	We recommend that the State agency develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-14-02503	Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace	3/26/2015	We recommend that the State agency oversee operations to ensure (1) the identification and correction of enrollment projection errors, (2) the use of better or updated enrollment data, and (3) the application of these data to allocate costs.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-15-00500	Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements	9/27/2018	We recommend that CMS educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop and share compliance best practices that may lead to improved internal controls.	Concur	2020	In progress	CMS released information in the August 29, 2019, MLN Connects newsletter. CMS is processing recommendation completion documentation to OIG.
A-01-15-00500	Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements	9/27/2018	We recommend that CMS work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented.	Concur	2019	In progress	CMS is drafting technical direction to encourage contractors to attend Administrative Law Judge (ALJ) hearings related to Inpatient Rehab Facility (IRF) policy. We are also working with the policy component to develop targeted IRF training for ALJs

A-01-15-00500	Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements	9/27/2018	We recommend that CMS reevaluate the IRF payment system, which could include: conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices, studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them, and considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute-care PPS system.	Concur	2022	In progress	CMS continuously evaluates the inpatient rehabilitation facility payment system on an annual basis. Recommendation implementation in progress.
A-01-15-00504	Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely-Failed Devices	9/28/2017	We recommend that CMS continue to work with the Accredited Standards Committee X12 to ensure that the DI is included on the next version of claim forms.	Concur	2020	In progress	CMS working with the X12 to ensure that the DI is included on the next version of claim transaction. the 837I Institutional claims version 7030 is currently being worked on. New transaction version is still out for public review. New transaction is pending going out for second public review.
A-01-15-00504	Shortcomings of Device Claims Data Complicate and Potentially Increase Medicare Costs for Recalled and Prematurely-Failed Devices	9/28/2017	We recommend that CMS require hospitals to use condition codes 49 or 50 on claims for reporting a device replacement procedure for all procedures that resulted from a recall or premature failure, regardless of whether the device was provided at no cost or with a credit of 50 percent or more.	Concur	2020	In progress	CMS working to submit closure notice.

[A-01-15-00515]()	Wisconsin Physicians Service Paid Providers for Hyperbaric Oxygen Therapy Services That Did Not Comply With Medicare Requirements	2/14/2018	We recommend that WPS recover the portion of the $300,789 in identified Medicare overpayments from the 73 providers for the 102 incorrectly billed claims that are within the 4-year reopening period in accordance with the 60-day rule.	Concur	2019	Awaiting Disposition	WPS recovered $266,969. Recommendation Closed in September 2019.
[A-01-15-00515]()	Wisconsin Physicians Service Paid Providers for Hyperbaric Oxygen Therapy Services That Did Not Comply With Medicare Requirements	2/14/2018	We recommend that WPS notify the 208 providers responsible for the remaining 44,820 nonsampled claims, with potential overpayments estimated at $42.3 million, so that those providers can investigate and return any identified overpayments in accordance with the 60-day rule and track any returned overpayments.	Concur	2020	In Progress	WPS has continued to received payments from providers in response to 60-day rule letters.
[A-01-15-02500]()	Vermont Did Not Properly Allocate Millions to Establishment Grants for a Health Insurance Marketplace	9/23/2016	We recommend that the State agency reduce establishment grant drawdowns after our audit period or refund $736,330 to CMS that was overdrawn in establishment grants as of September 30, 2014.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
[A-01-15-02500]()	Vermont Did Not Properly Allocate Millions to Establishment Grants for a Health Insurance Marketplace	9/23/2016	We recommend that the State agency develop policies and procedures that explain how to develop a CAP based on the relative benefits received and when to reassess and revise the CAP and related allocations on a retroactive or prospective basis.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-01-15-02500	Vermont Did Not Properly Allocate Millions to Establishment Grants for a Health Insurance Marketplace	9/23/2016	We recommend that the State agency amend its CAP for July 2012 through September 2013 and either refund $10.5 million to CMS that was allocated to the establishment grants using a methodology that included a material defect or work with CMS to determine the appropriate allocation to the establishment grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-15-02500	Vermont Did Not Properly Allocate Millions to Establishment Grants for a Health Insurance Marketplace	9/23/2016	We recommend that the State agency use the actual enrollment data for April through September 2014 to determine the appropriate allocation to the establishment grants, work with CMS to determine what portion of $13.9 million was properly allocated to the establishment grants, and refund any portion that was not properly allocated.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-15-02500	Vermont Did Not Properly Allocate Millions to Establishment Grants for a Health Insurance Marketplace	9/23/2016	We recommend that the State agency ensure that procedures are in place and the updated policies are followed for the reconciliation of reported grant expenditures and drawdowns to cumulative actual spending.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences.	Concur	2020	In Progress	The State continues to work with community-based providers to identify and report all Critical Incidents. Quarterly meetings were held to review Critical Incidents and discuss timeliness and completeness of the reports, including the completion of provider administrative reviews to follow-up. The State prompts discussion about the provider's responsibility to report all Critical Incidents per the Department's Reportable Events System rule. The State agency issued notifications to family centered home providers to provide information on their roles as reporters of Critical Incidents. CMS continues to monitor the state's corrective action.

A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency work with community-based providers to ensure that administrative reviews are conducted and reported appropriately.	Concur	2020	In Progress	The State is continuing to work with providers to ensure that the Provider Follow Up Report is entered correctly and can be captured for compliance tracking. CMS continues to monitor the state's corrective action.
A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency provide training to the State agency's and community-based providers' staffs regarding the HCBS waiver and State requirements for critical incident reporting.	Concur	2020	In Progress	The State agency continues to provide training. The quarterly provider meetings are used as a forum to share information about HCBS, including the 2014 settings regulations, and rights of individuals with intellectual disabilities and autism. CMS continues to monitor the state's corrective action.

A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency perform trend analysis and analytical procedures, such as a data match, to provide community-based providers with reports that identify patterns and trends to prevent reoccurrences of critical incidents and determine the number and percentage of critical incidents reported in required timeframes.	Concur	2020	In Progress	The State agency uses the Critical Incident dashboard as the central repository of data to provide community-based providers with reports that identify patterns and trends to prevent reoccurrences of critical incidents and determine the number and percentage of critical incidents reported in required timeframes. The dashboard also uses MaineCare data to match Emergency Department visits with Critical Incident reports. CMS continues to monitor the state's corrective action.
A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency report appropriately all restraint usage and rights violations to DRM.	Concur	2020	In Progress	The State agency reported all restraint usage and rights violations to Disability Rights Maine (DRM). Reports of Restraints are sent to DRM through email on a spreadsheet generated using Cognos software. Rights violations are routed through the Enterprise Information System, the electronic client data system used for the Reportable Events System. A daily status report is used to confirm that the electronic system routed the rights violations correctly to DRM. The State agency maintains a record of the reports to DRM. CMS continues to monitor the state's corrective action.
A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency investigate and immediately report to the appropriate district attorney’s office or law enforcement all critical incidents involving	Concur	2020	In Progress	The State agency continues to investigate and immediately report to the appropriate District Attorney’s offices all Critical Incidents involving suspected abuse, neglect, or exploitation. CMS continues to monitor the state's corrective action.

			suspected abuse, neglect, or exploitation.				
A-01-16-00001	Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	8/9/2017	We recommend that the State agency fully implement its own regulations regarding the reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community residences. Specifically, we recommend that the State agency ensure community-based providers report to the State agency all beneficiary deaths and that the State agency analyzes, investigates, and reports these deaths to law enforcement or OCME.	Concur	2020	In Progress	The state agency continues to ensure that community-based providers reported all beneficiary deaths as Critical Incidents by cross checking client data and provider reports of deaths with Maine's Death Registry maintained by the Maine Center for Disease Control and Prevention, Vital Statistics. Adult Protective Services analyzed each report of death and investigated, as appropriate. Deaths that may have been the result of abuse, neglect or exploitation were reported to law enforcement or the Office of the Chief Medical Examiner. CMS continues to monitor the state's corrective action.
A-02-07-01050	Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Year 2007	11/4/2011	We recommend that the State agency refund $5,023,626 to the Federal Government.	Concur	2020	In Progress	CMS is working on a revised disallowance package to include the soft finding of $7,954,944.
A-02-07-01050	Review of Medicaid Administrative Costs Claimed by New Jersey for State	11/4/2011	We recommend that the State work with CMS to determine what portion of the remaining $7,954,944 in Medicaid administration costs claimed for FY 2007 was allowable under Federal requirements,	Concur	2020	In Progress	CMS is working on a revised disallowance package to include the soft finding of $7,954,944.

	Fiscal Year 2007						
A-02-07-01054	Review of Medicaid Personal Care Services Claims Made by Providers in New York City	6/8/2009	We recommend that the State refund $275,327,274 to the Federal Government.	Concur	2020	In Progress	The disallowance package was cleared by OGC on April 23, 2014 and is with CMS Central Office. CMS is working to process the disallowance package during FY 2020.
A-02-08-01005	Review of Medicaid Personal Care Services Claims Made by Providers in New York State	10/13/2010	We recommended that the State refund $100,335,472 to the Federal Government.	Concur	2020	In Progress	The disallowance package cleared OGC on 4/24/2014 and is in CMS Central Office. CMS is working to process the disallowance package during FY 2020.
A-02-08-01006	Review of New York's Medicaid Rehabilitative Services Claims Submitted by Community Residence Providers	1/3/2011	We recommended that the State agency refund $207,569,115 to the Federal Government. As a result of additional documentation provided by the state, the OIG recalculated the overpayment to be $203,641,959. This finding is cleared.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 1/12/2015. CMS is working to process the disallowance package during FY 2020.
A-02-08-01009	Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006	3/8/2012	We recommend that the State agency refund $22,481,421 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 7/20/2015. CMS is working to process the disallowance package during FY 2020.
A-02-08-01017	Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by	11/30/2011	We recommend that DOH refund $16,951,335 to the Federal Government.	Concur	2020	In Progress	CMS is working to prepare a disallowance package, while also working with NYS to resolve collecting the $16,951,335 FFP.

	Providers in New York City,						
A-02-09-01002	Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey	12/29/2011	The State refund $145,405,192 to the Federal Government	Concur	2020	In Progress	CMS is working with state on a disallowance and possible settlement.
A-02-09-01005	Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Venture Forthe, Inc., From January 1, 2005, Through December 31, 2007	5/25/2011	We recommended that the State agency refund $3,156,501 to the Federal Government.	Concur	2020	In Progress	The amount was revised to $220,653 and the disallowance package was sent to CMS Central Office on 7/18/2018. CMS is working to process the disallowance package during FY 2020.
A-02-09-01006	Review of Medicaid Payments for Services Provided Under New York's Section 1915(c) Traumatic Brain Injury Waiver at Belvedere of Albany, LLC, From January 1, 2005, Through December 31, 2007	6/1/2011	We recommended that the State agency refund $1,555,291 to the Federal Government.	Concur	2020	In Progress	The amount was revised to $11,094 and the disallowance package was sent to CMS Central Office on 7/18/2018. CMS is working to process the disallowance package during FY 2020.

A-02-09-01028	Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey	5/31/2012	We recommend that the State refund $30,589,719 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 11/10/15. CMS is working to process the disallowance package during FY 2020.
A-02-10-01001	New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Nurses, Inc., in Accordance With Federal and State Requirements	9/24/2012	We recommend that the State agency refund $774,274 to the Federal government.	Concur	2020	In Progress	CMS is working with state on a disallowance and possible settlement.
A-02-10-01002	Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP	4/20/2012	We recommend that the State agency refund $8,177,970 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to OGC on 1/6/16. CMS is working to process the disallowance package during FY 2020.
A-02-10-01022	New York Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims	11/29/2012	We recommend that the State agency refund $69,121,473 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 2/3/16. CMS is working to process the disallowance package during FY 2020.

	Submitted by Certified Home Health Agencies in New York City						
A-02-10-01024	New York Improperly Claimed Medicaid Reimbursement for Family-Based Treatment Rehabilitation Services	3/26/2013	We recommend that the State agency refund $27,467,320 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 11/7/2017. CMS is working to process the disallowance package during FY 2020.
A-02-10-01029	Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver Program From January 1, 2005, through December 31, 2007	4/23/2012	HHS-OIG recommended that the New Jersey Department of Human Services (State agency) refund $60,740,637 to the Federal Government.	Concur	2020	In Progress	CMS is working with the State on a disallowance and possible settlement.
A-02-10-01042	New Jersey Claimed Excessive Medicaid Disproportionate Share Hospital Payments to Four Hospitals	3/27/2014	We recommend that the State agency refund $22,004,768 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 10/4/2017. CMS is working to process the disallowance package during FY 2020.
A-02-10-01043	New York's Claims for Medicaid Services Provided Under Its Traumatic Brain Injury	5/21/2013	We recommended that the New York Department of Health (Health Department) refund $54,265,195 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 7/18/18. CMS is working to process the disallowance package during FY 2020.

	Waiver Program Did Not Comply With Certain Federal and State Requirements						
A-02-11-01008	New York State Improperly Claimed Medicaid Reimbursement for Some Home Health Services Claims Submitted by Certified Home Health Agencies	9/20/2013	We recommend that the State agency refund $31,482,913 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 2/3/16. CMS is working to process the disallowance package during FY 2020.
A-02-11-01014	New Jersey Claimed Medicaid Hospice Services That Were Not in Compliance With Federal and State Requirements	4/30/2015	We recommend that the State agency: refund $8,405,262 to the Federal Government.	Concur	2020	In Progress	CMS requested NJ to process a 64.9, line 10A adjustment for $8,405,262. CMS is still working with the State on corrective action.
A-02-11-01014	New Jersey Claimed Medicaid Hospice Services That Were Not in Compliance With Federal and State Requirements	4/30/2015	We recommend that the State agency: continue to monitor hospices to ensure that they comply with Federal and State requirements.	Concur	2020	In Progress	CMS is working with the state on an acceptable corrective action plan.
A-02-11-01038	New York Claimed Hospital-Based Continuing Day Treatment Services That Were Not in	9/5/2013	That NYS DOH refund $8,281,766 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 1/6/16. CMS is working to process the disallowance package during FY 2020.

	Compliance With Federal and State Requirements						
A-02-12-01004	New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims	2/26/2015	The State agency should refund $12,063,508 to the Federal Government	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 11/17/16. CMS is working to process the disallowance package during FY 2020.
A-02-12-01011	New York Claimed Nonhospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements	7/3/2014	We recommend the State agency refund $18,093,953 to the Federal government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 5/9/17. CMS is working to process the disallowance package during FY 2020.
A-02-13-01016	New York State Improperly Claimed Medicaid Reimbursement for Some Adult Day Health Care Services	12/23/2015	We recommend that the State agency refund $70,486,492 to the Federal Government.	Concur	2020	In Progress	CMS determined a revised disallowance amount of $62,977,786. The revised disallowance package was sent to CMS Central Office on 9/28/18. CMS is working to process the disallowance package during FY 2020.
A-02-13-01021	New York Overpaid Certain Medicaid Mental Health Services Providers	6/20/2016	We recommend that the State agency: refund $8,106,746 to the Federal Government for COPS and CSP overpayments for the period 2009 through 2012	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 11/14/17. CMS is working to process the disallowance package during FY 2020.

A-02-13-01021	New York Overpaid Certain Medicaid Mental Health Services Providers	6/20/2016	We recommend that the State agency: continue working with OMH to collect the additional $54.9 million ($27.4 million Federal share) in overpayments for the period 2003 through 2008 and return the applicable Federal share to CMS	Concur	2020	In Progress	CMS is working with the state to determine potential overpayments.
A-02-13-01021	New York Overpaid Certain Medicaid Mental Health Services Providers	6/20/2016	We recommend that the State agency: exhaust all legal efforts to collect the $5.4 million ($2.7 million Federal share) in overpayments that the State indicated were not collectable because of provider bankruptcy or business closure	Concur	2020	In Progress	CMS is working with the state to exhaust all legal efforts to collect the $5.4 million ($2.7 million Federal share) in overpayments
A-02-13-01021	New York Overpaid Certain Medicaid Mental Health Services Providers	6/20/2016	We recommend that the State agency: identify any overpayments made between the end of our audit period (December 2012) and when the State ended the COPS and CSP programs (October 2013) and refund the applicable Federal share	Concur	2020	In Progress	CMS is working with the state to identify any overpayments.
A-02-13-01022	Some of New Jersey's Claims for Medicaid Personal Care Services Did Not Comply With Federal and State Requirements	8/26/2015	We recommend that the State agency: refund $32,236,308 to the Federal Government	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 3/28/19. CMS is working to process the disallowance package during FY 2020.
A-02-13-01029	New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance With Federal and State Requirements	12/27/2016	We recommended that the State agency: refund $94,830,718 to the Federal Government	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 4/11/19. CMS is working to process the disallowance package during FY 2020.

A-02-13-01031	AgeWell Physical Therapy & Wellness, P.C., Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services	6/15/2015	Refund $1,377,382 to the Federal Government.	Concur	2020	In Progress	The provider appealed the overpayment. Overpayment was reduced to $609,071 after QIC determination. The remaining balance been appealed to the ALJ.
A-02-14-01003	New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims in Ulster County	3/4/2015	We recommend that the State agency: refund $6,276,189 to the Federal Government	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 11/17/16. CMS is working to process the disallowance package during FY 2020.
A-02-14-01005	Medicare Compliance Review of Excellent Home Care Services, LLC	7/14/2016	We recommend that the Agency refund to the Medicare contractor $6,382,323 in estimated net overpayments for claims incorrectly billed that are within the 3-year claims recovery period.	Concur	2020	In Progress	The provider appealed the overpayment. A balance of $769,733 has been appealed to the ALJ.
A-02-14-01009	New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments	8/25/2016	State agency refund to the Federal government $2,270,213 in net overpayments made to 15 hospitals	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 3/20/19. CMS is working to process the disallowance package during FY 2020.
A-02-14-01009	New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments	8/25/2016	The State agency adjust the 15 hospitals' remaining incentive payments to account for the incorrect calculations	Concur	2020	In Progress	CMS has requested more detail from the state concerning the recovery of payments.

A-02-14-01009	New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments	8/25/2016	The State agency review the calculations for the hospitals not included in the 33 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified	Concur	2020	In Progress	CMS has requested more detail from the state concerning the recovery of payments.
A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: refund $30,744,840 to the Federal Government	Concur	2020	In Progress	The disallowance package was sent to OGC on 4/10/18. CMS is working to process the disallowance package during FY 2020.
A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: work with the State's DOH to ensure partial hospitalization services are provided by appropriately licensed hospital. 3/21/18-Sent email to CMS for status, awaiting response	Concur	2019	Awaiting Disposition	CMS confirmed that the State's Department of Health now licenses all hospitals so that partial hospitalization services are provided by appropriately licensed hospitals. CMS concurs with this corrective action and considers the finding closed.
A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: issue guidance to providers on Federal and State requirements for claiming Medicaid reimbursement for partial hospitalization services. 3/21/18, sent email to CMS for status of findings, awaiting response	Concur	2019	Awaiting Disposition	CMS confirmed that the State provides notice to partial care providers of all regulations governing partial care services. CMS concurs with the corrective action and considers the finding closed.

A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: improve its monitoring of partial hospitalization services providers to ensure compliance with Federal and State requirements	Concur	2019	Awaiting Disposition	CMS confirmed that the State now visits hospitals that provide partial hospitalization services on a regular basis and prepares reports on their visits. CMS concurs with the corrective action and considers the finding closed.
A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: review and revise payment controls to ensure the correct rates are paid for partial hospitalization services. 3/21/18, sent email to CMS for status of findings, awaiting response	Concur	2020	In Progress	CMS continues to work with the State to discuss claims review.
A-02-14-01015	New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements	4/19/2017	We recommend that the State agency: work with CMS to identify claims outside of our audit period that were paid at an incorrect rate or for services that were not provided by a facility licensed as a hospital. 3/21/18, sent email to CMS for status of findings, awaiting response	Concur	2020	In Progress	CMS continues to work with the State to discuss claims review.
A-02-14-02006	CMS's Internal Controls Did Not Effectively Ensure the Accuracy of Aggregate Financial Assistance Payments	6/16/2015	We recommend that CMS implement a computerized system so State marketplaces can submit enrollee eligibility data.	Concur	2020	Awaiting Disposition	As of October 2019, this recommendation is closed.

	Made to Qualified Health Plan Issuers Under the Affordable Care Act						
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency work with CMS to ensure that costs claimed after our audit period are allocated correctly using an updated cost allocation methodology.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency amend the CAP and the Advance Planning Documents for the period April 1 through December 31, 2014, to reflect the updated cost allocation methodology.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency develop written policy that explains how to perform cost allocations and emphasizes the necessity to use updated, better data when available.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency ensure application of updated, better data to properly allocate costs and (2) proper allocation of costs for all allocable project components.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency follow established procedures to ensure that only costs resulting from obligations of the funding period are claimed for Federal reimbursement.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency amend its CAP for the period August 2011 through March 2014 and either refund $93,393,879 to CMS that was allocated to the establishment grants using a methodology that included a material defect or work with CMS to determine the appropriate allocation to the establishment grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency refund to CMS $55,261,734, consisting of $49,493,613 that was misallocated to the establishment grants by not using updated, better data and $5,768,121 that was misallocated to the establishment grants for in-person enrollment assistance costs that also benefited Medicaid, or work with CMS to resolve the amounts misallocated to the establishment grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-14-02017	New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace	11/21/2016	We recommend that the State agency refund to CMS $998,899 for costs that were incurred after the funding period had ended on an establishment grant.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-02-15-01010	New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	11/27/2017	We recommend the State agency refund $300,452,930 in Federal Medicaid reimbursement claimed based on payment rates that incorporated unallowable costs. This disallowance is based on $220,314,119 calculated by removing allowable costs and RMS study based on correct activity moments plus $80,138,811 which was claimed based on a pending amendments to its State plan. The $220,314,119 includes the effect of including unallowable costs in the rate pool as follows: Unpaid Pension Costs-$435,287,077, Unallowable disabilities teacher-consultant salaries$61,528,162, and Special education or non health related services$75,379,253. The rates were recalculated using corrected random moment timestudy activity codes that were changed by the State agency's contractor. The contractor recoded 235 of the employees' responses, we determined that 203 were incorrect.	Concur	2020	In Progress	CMS is still working to finalize the State Plan Amendment while also working with the Department of Justice on a possible settlement with the state. CMS will submit an OCD once the SPA is approved or a settlement is reached, whichever occurs sooner
A-02-15-01010	New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	11/27/2017	We recommend that the State agency revise its payment rates to comply with Federal requirements.	Concur	2020	In Progress	CMS is still working to finalize the State Plan Amendment while also working with the Department of Justice on a possible settlement with the state. CMS will submit an OCD once the SPA is approved or a settlement is reached, whichever occurs sooner

A-02-15-01010	New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	11/27/2017	We recommend that the State agency work with CMS to determine the allowable amount of the remaining $306,233,377 set-aside because the rates included unallowable costs that could not be quantified. Specifically, the payment rates incorporated non-Medicaid related costs lumped together into activity code with Medicaid related costs. In addition, the sample moments used were not supported	Concur	2020	In Progress	CMS is still working to finalize the State Plan Amendment while also working with the Department of Justice on a possible settlement with the state. CMS will submit an OCD once the SPA is approved or a settlement is reached, whichever occurs sooner
A-02-15-01019	Most of New York's Claims for Federal Reimbursement for Monthly Personal Emergency Response Service Charges Did Not Comply With Medicaid Requirements	4/24/2018	Refund $5,516,838 to the Federal Government	Concur	2020	In Progress	CMS is drafting a disallowance package.
A-02-15-01026	New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments	9/11/2017	We recommend that DOH ensure that future contracts with MLTC plans include provisions that allow the State agency to recover payments when plans do not comply with contract requirements. This measure could have saved the Medicaid program approximately $1.4 billion ($717 million Federal share) during SFY 2014.	Concur	2019	Awaiting Disposition	CMS confirmed that the DOH has a Surveillance Unit within MLTC that conducts independent operational surveys of the MLTC Partial Capitation plans to promote the integrity of the MLTC Program through provider/contractor audits and policy reviews, identify and monitor program vulnerabilities, and provide support, assistance, and education to the plans. CMS concurs with the corrective action and considers the finding closed.

A-02-15-01026	New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments	9/11/2017	We recommended that the State agency develop procedures to monitor MLTC plans for compliance with Federal and State requirements detailed in its contracts with the plans, including (1) documenting initial eligibility assessments and reassessments and conducting them in a timely manner using a registered nurse, (2) providing services according to a written care plan, (3) enrolling and retaining only those beneficiaries who require more than 120 days of community-based services, (4) disenrolling beneficiaries in a timely manner, (5) providing services according to a written care plan that is personalized and specifically addresses beneficiaries' unique medical and psychosocial needs, and (6) actively coordinating beneficiaries' medical and psychosocial care.	Concur	2020	In Progress	The State added provision language to Partial Capitation MLTC Contract in effect from 1/1/2017 to 12/31/2021 that enhance the State Agencies ability to make recoveries recover payments when plans do not comply with contract requirements. CMS is reviewing the State's corrective action.
A-02-15-01027	Some Hospitals in Medicare Jurisdiction E Claimed Residents as More Than One Full-Time Equivalent	7/17/2017	We recommend that Noridian recover $434,531 in excess Medicare GME reimbursement paid to 36 hospitals in MAC Jurisdiction E.	Concur	2020	In Progress	CMS is awaiting the disposition of cost report appeals before closing recommendation.
A-02-15-01028	Some Hospitals in Medicare Jurisdiction F Claimed Residents as More Than One Full-Time Equivalent	7/17/2017	We recommend that Noridian recover $365,387 in excess Medicare GME reimbursement paid to 21 hospitals in MAC Jurisdiction F.	Concur	2020	In Progress	Noridian is unable to reopen cost reports for the 21 hospitals because the overpayment either did not exceed Noridian's reopening threshold or were past the 3 year reopening window. CMS continues to monitor corrective action.

A-02-15-02008	New York Did Not Comply With Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs	12/22/2017	We recommend that the State agency work with CMS to ensure that Maximus contract costs claimed after our audit period are properly allocated.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-15-02008	New York Did Not Comply With Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs	12/22/2017	We recommend that the State agency refund to CMS $19,586,165 for costs that may have been misallocated to the establishment grants or work with CMS to determine the appropriate allocation to the grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-15-02008	New York Did Not Comply With Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs	12/22/2017	We recommend that the State agency refund to CMS $797,096 for unallowable profit fees or work with CMS to determine the appropriate amount that should have been claimed to the grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-15-02008	New York Did Not Comply With Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs	12/22/2017	We recommend that the State agency refund to CMS $32,083 for unallowable G&A costs and related profit fees.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the	8/8/2018	We recommend that CMS work with Treasury and QHP issuers to collect improper financial assistance payments, which we estimate to be $434,398,168, for policies for which the payments were not authorized in accordance with Federal requirements	Concur	2021	In Progress	We are currently documenting our activities to date and the amount of the questioned costs that can be sustained.

	2014 Benefit Year						
A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year	8/8/2018	We recommend that CMS work with Treasury and QHP issuers to resolve the potentially improper financial assistance payments, which we estimate to be $504,889,518, for policies for which there was no documentation provided to verify enrollees had paid their premiums	Concur	2021	In progress	We are currently documenting our activities to date and the amount of the questioned costs that can be sustained.
A-02-15-02013	CMS Did Not Always Accurately Authorize Financial Assistance Payments to Qualified Health Plan Issuers in Accordance With Federal Requirements During the 2014 Benefit Year	8/8/2018	We recommend CMS clarify guidance for QHP issuers on Federal requirements for terminating an enrollee's coverage when the enrollee fails to pay his or her monthly premium.	Concur	2021	In progress	We currently have letters to issuers in clearance regarding the 2014 process. Once those letters have cleared and have been sent out, that will resolve this recommendation.
A-02-16-01026	New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance	6/4/2018	We recommend that the State agency refund $74,871,340 to the Federal Government.	Concur	2020	In Progress	The disallowance package was sent to CMS Central Office on 1/8/19. CMS is working to process the disallowance package during FY 2020.

	Services That Did Not Meet Medicaid Requirements						
A-03-00-00216	Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers	9/11/2001	We recommended that CMS provide States with definitive guidance for calculating the upper payment limit (UPL), which should include using facility-specific UPLs that are based on actual cost report data.	Concur	2019	In Progress	Regulation under development
A-03-12-00205	The District of Columbia Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	8/21/2014	We recommend the State Agency refund to the Federal Government $2,392,539 (Federal share) for single-source and top-20 multiple-source physician-administered drug claims that were ineligible for Federal reimbursement	Concur	2020	In Progress	The proposed $1,343,363 disallowance is in CMS Central Office awaiting review and approval.
A-03-12-00205	The District of Columbia Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	8/21/2014	We recommend the State agency work with CMS to determine and refund the unallowable Federal reimbursement for physician-administered drugs claimed without NDCs after January 1, 2011.	Concur	2020	In Progress	The proposed $1,343,363 disallowance is in CMS Central Office awaiting review and approval.
A-03-14-00406	West Virginia Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	8/10/2016	Review the calculations for the hospitals not included in the five we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.	Concur	2020	In Progress	State returned the money on the CMS-64 during 3Q2019 on Line 10A. CMS is confirming this is the final amount. Once confirmed, we will submit an OCD to close the recommendation

A-03-15-00202	Delaware Did Not Bill Manufacturers for Some Rebates for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	12/30/2016	work with CMS to resolve the drug utilization data without valid NDCs by determining the correct NDCs, billing manufacturers for the estimated $230,045 ($126,524 Federal share) in rebates, and refunding the Federal share of rebates collected	Concur	2019	Awaiting Disposition	State returned $126,524 on Line 10A of their CMS-64 for 3Q2019. CMS considers the finding closed.
A-03-17-00200	Virginia Did Not Claim Some Medicaid Administrative Costs for Its Medallion 3.0 Waiver Program In Accordance With Federal Requirements	6/25/2018	Reclassify $2,331,902 ($1,165,951 Federal share) in administrative costs that directly benefited Virginia's CHIP programs, not the Waiver program	Concur	2020	In Progress	Disallowance is in process
A-03-17-00200	Virginia Did Not Claim Some Medicaid Administrative Costs for Its Medallion 3.0 Waiver Program In Accordance With Federal Requirements	6/25/2018	Refund to the Federal government $7,674,911 for administrative costs that were not identified in the CAP	Concur	2020	In Progress	Disallowance is in process
A-04-14-04029	Providers Did Not Always Reconcile Patient Records With Credit Balances and Report and Return the Associated Medicaid Overpayments	8/26/2015	We recommended that CMS issue Medicaid regulations to clarify the requirements of the Affordable Care Act that parallel its proposed Medicare rules and require that States ensure that providers exercise reasonable diligence to identify, report, and return overpayments.	Concur	2021	In progress	Pending regulation and the development of a Medicaid overpayment rule mirroring recent 6037-F.

	to State Agencies						
A-04-15-04037	North Carolina Improperly Claimed Federal Reimbursement for Some Medicaid Nonemergency Transportation Services	11/18/2016	We recommended that the State agency refund $3,121,544 to the Federal Government for the additional Federal reimbursement received for NEMT expenditures improperly claimed at the FMAP rate.	Concur	2020	In Progress	CMS advised the State to return the Federal Share on the 09302019 CMS 64 Line 10A.
A-04-15-04037	North Carolina Improperly Claimed Federal Reimbursement for Some Medicaid Nonemergency Transportation Services	11/18/2016	We recommended that the State agency refund $12,011,228 to the Federal Government for unallowable NEMT services identified in our sample.	Concur	2020	In Progress	CMS advised the State to return the Federal Share on the 09302019 CMS 64 Line 10A.
A-04-15-05065	Alabama Did Not Adequately Secure Its Medicaid Data and Information Systems	8/31/2017	We recommend that Alabama establish policies and procedures to assess the risk for its network connectivity to Medicaid systems maintained by its contractors.	Concur	2018	Awaiting Disposition	The State added the criteria to assess the risk of network connectivity to contractor systems to the Medicaid data across the Agency and contractor network boundaries to the Agency's biennial Risk Assessment. Risk Assessment completed 12/29/17. CMS has reviewed the corrective action plan and it is acceptable and working as anticipated. This finding is closed.
A-04-16-04054	North Carolina Did Not Comply With Federal and State Requirements When Making Medicaid Cost-Sharing Payments for Professional	11/7/2017	We recommended that the State agency ensure that future changes to Medicaid payment methodologies comply with the Medicaid State plan.	Concur	2019	Awaiting Disposition	State staff confirmed that the procedural changes have been implemented. The corrective action plan is acceptable and has been implemented. CMS has confirmed that the corrective action plan is working as anticipated. This finding is closed.

	Medical Servi ces						
A-04-16-04054	North Carolina Did Not Comply With Federal and State Requirements When Making Medicaid Cost-Sharing Payments for Professional Medical Servi ces	11/7/2017	We recommended that the State agency refund $41,188,318 to the Federal Government for cost-sharing payments for professional medical services that did not comply with Federal and State requirements.	Concur	2020	In Progress	CMS advised the State to return the Federal Share on the 09302019 CMS 64 Line 10A.
A-04-17-04056	Most Medicare Claims for Replacement Positive Airway Pressure Device Supplies Did Not Comply With Medicare Requirements	6/7/2018	We recommended that CMS work with Medicare contractors to establish periodic reviews of claims for replacement PAP device supplies and take remedial action for suppliers that the contractors find consistently bill claims that do not meet Medicare requirements, which could have saved Medicare an estimated $631,272,181 over a 2-year period.	Concur	2020	In progress	CMS expects to receive the final SMRC PAP project report by December 31, 2019. CMS will review the final project report and determine if additional action is warranted.
A-05-07-00076	Review of Medicaid Participation Eligibility for One Indiana State-owned Psychiatric Hospital for the Period July 1, 1996, Through June 30, 2007	3/30/2009	We recommend that the State agency refund $16,298,423 to the Federal Government for Medicaid inpatient psychiatric service payments made to hospital A from July 1, 1996, through June 30, 2007	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.

A-05-07-00076	Review of Medicaid Participation Eligibility for One Indiana State-owned Psychiatric Hospital for the Period July 1, 1996, Through June 30, 2007	3/30/2009	We recommend that the State agency identify and refund the Federal share of additional unallowable Medicaid payments to hospital A for inpatient psychiatric services provided after June 30, 2007	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-07-00076	Review of Medicaid Participation Eligibility for One Indiana State-owned Psychiatric Hospital for the Period July 1, 1996, Through June 30, 2007	3/30/2009	We recommend that the State agency ensure that Medicaid payments for inpatient psychiatric services are made only to eligible hospitals.	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-07-00077	Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	4/20/2009	We recommend that CMS consider adjusting the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, which may reduce payments by an estimated $97.6 million	Non-concur	NA	Awaiting Disposition	CMS continues to non concur; no additional action has taken place.

A-05-07-00077	Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005	4/20/2009	We recommended that CMS consider adjusting the estimated number of evaluation and management (E&M) services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries or using the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule..	Non-concur	NA	Awaiting Disposition	CMS continues to non concur; no additional action has taken place.
A-05-09-00021	Review of Indiana's Reporting Fund Recoveries for Federal and State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2000 Through 2008	10/26/2010	We recommended that the State agency include unreported Medicaid overpayments of $61,644,098 on the CMS-64 and refund $38,858,614 to the Federal Government.	Concur	2020	In Progress	The state has returned $11,758,489 FFP based on a re-ran projection through an OIG software program. An amended OCD is in process.
A-05-09-00053	Wisconsin Physicians Service Insurance Corporation Claimed Unallowable Medicare Part B Administrative Costs for Fiscal Year 2013	5/1/2012	We recommend that CMS adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $49 million	Concur	2021	In Progress	CMS working to consider these services for inclusion in the potentially misvalued codes initiative.
A-05-09-00053	Wisconsin Physicians Service Insurance Corporation Claimed Unallowable Medicare Part B	5/1/2012	We recommend that CMS use the results of this audit during the annual update of the physician fee schedule.	Concur	2021	In Progress	CMS working to consider these services for inclusion in the potentially misvalued codes initiative.

	Administrative Costs for Fiscal Year 2013						
A-05-09-00054	Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	5/1/2012	We recommend that CMS adjust the estimated number of E&M services within cardiovascular global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $14.6 million	Concur	2021	In Progress	CMS in progress
A-05-09-00054	Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided	5/1/2012	We recommend that CMS use the results of this audit during the annual update of the physician fee schedule.	Concur	2021	In Progress	CMS in progress
A-05-09-00103	Review of Michigan's Reporting Fund Recoveries for State Medicaid Programs on the Form CMS-64 for Federal Fiscal Years 2008 and 2009	9/17/2010	We recommended that the State agency include unreported Medicaid overpayments of $2,340,182 on the CMS-64 and refund $1,320,131 to the Federal Government.	Concur	2020	In Progress	The state has provided supporting documentation for CMS review. CMS has submitted follow-up questions and will continue to work with the state until documentation is sufficient to resolve the finding. We anticipate this issue will be resolved by February 28, 2020.
A-05-10-00046	Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One	8/3/2011	We recommended that the State agency refund $82,929,010 to the Federal Government for its share of inpatient psychiatric service and disproportionate share hospital (DSH) payments made to hospital A for claims with	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.

	Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31. 2009		dates of service outside the regulatory gap period.				
A-05-10-00046	Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31. 2009	8/3/2011	We recommended that the State agency identify and refund the Federal share of any additional payments made to hospital A for claims with dates of service after the audit period if neither the State agency nor hospital A can demonstrate the hospital's compliance with Federal inpatient psychiatric hospital service requirements.	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-10-00046	Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000 Through December 31, 2009	8/3/2011	We recommended that the State agency work with CMS to determine whether the State agency should refund an additional $12,590,126 to the Federal Government for its share of payments made to hospital A for claims with dates of service during the regulatory gap period.	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.

A-05-11-00016	Northwestern University Did Not Always Comply With Federal Requirements To Perform Risk Assessments of Subrecipients, but Claimed Allowable Costs	9/28/2015	Review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.	Concur	2016	Awaiting Disposition	NGS completed their review of the outlier information for cost reports subsequent to the OIG review period and provided CMS with a spreadsheet summarizing this. CMS reviewed the documentation upon receipt and verified and confirmed that the cost reports that should have been referred to CMS for outlier reconciliation were properly referred and reconciled in accordance with Federal guidelines. This finding is closed.
A-05-11-00016	Northwestern University Did Not Always Comply With Federal Requirements To Perform Risk Assessments of Subrecipients, but Claimed Allowable Costs	9/28/2015	Review the 24 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the $102,498,576 in associated outlier payments due to the Federal Government (22 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare.	Concur	2020	In Progress	NGS reported that 5 cost report NPRs are still on hold per the pre-2005 SSI and is working with CMS on resolution.
A-05-11-00016	Northwestern University Did Not Always Comply With Federal Requirements To Perform Risk Assessments of Subrecipients, but Claimed Allowable Costs	9/28/2015	Work with CMS to resolve the $9,778 in outlier payments associated with one claim that we could not recalculate.	Concur	2020	In Progress	NGS reported that 5 cost report NPRs are still on hold per the pre-2005 SSI and is working with CMS on resolution.

A-05-11-00016	Northwestern University Did Not Always Comply With Federal Requirements To Perform Risk Assessments of Subrecipients, but Claimed Allowable Costs	9/28/2015	Review the 10 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to recoup $19,689,662 in funds and associated interest from health care providers (8 cost reports), and refund that amount to the Federal Government.	Concur	2020	In Progress	NGS reported that 5 cost report NPRs are still on hold per the pre-2005 SSI and is working with CMS on resolution.
A-05-11-00019	Cahaba Government Benefit Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	3/30/2015	Work with CMS to resolve the $113,613 in outlier payments associated with one claim that we could not recalculate.	Concur	2020	In Progress	Cahaba has run into a technical issue where the lump sum utility report that is used in the computation is not picking up the short stay outlier payments for long term care hospitals and is working with CMS for resolution.
A-05-11-00019	Cahaba Government Benefit Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	3/30/2015	Review the seven cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup at least $8,488,306 in funds and associated interest from health care providers, and refund that amount to the Federal Government	Concur	2020	In Progress	Cahaba has collected a total of $1.3 million. The remaining balance are for cost reports on hold. Cahaba is working with CMS on resolution.

A-05-11-00023	Novitas Solutions, Inc. (Formerly Highmark Medicare Services, Inc.), Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments	3/27/2015	Review the 5 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup $11,477,187 in funds and associated interest from health care providers, and refund that amount to the Federal Government	Concur	2020	In Progress	Novitas informed CMS that they are still waiting for the FISS history to be available so that they can work the old outlier reconciliations.
A-05-11-00040	Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable	9/27/2013	We recommend that the State agency refund $998,466 to the Federal Government.	Concur	2020	In Progress	CMS has instructed the state to return the FFP using a 10A adjustment on the CMS-64 report
A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	Reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
A-05-12-00020	Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates	4/16/2014	Seek legislation that would exempt the reduced expenditures as a result of lower OPPS payment rates from budget neutrality adjustments for ASC-approved procedures.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

A-05-12-00040	Indiana Improperly Claimed Federal Reimbursement for Most Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Evansville Psychiatric Children's Center	5/30/2013	We recommend that the State Medicaid agency: refund $7,567,455 to the Federal Government for its share of inpatient psychiatric service and DSH payments made to Evansville for claims with dates of service outside the regulatory gap period when it did not demonstrate compliance with the basic and special Medicare CoP	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00040	Indiana Improperly Claimed Federal Reimbursement for Most Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Evansville Psychiatric Children's Center	5/30/2013	We recommend that the State Medicaid agency: work with CMS to determine whether the State Medicaid agency should refund an additional $345,889 to the Federal Government for its share of payments made to Evansville for claims with dates of service during the regulatory gap period	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00040	Indiana Improperly Claimed Federal Reimbursement for Most Medicaid Inpatient Psychiatric Hospital Service and Disproportion	5/30/2013	We recommend that the State Medicaid agency: ensure that Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the basic and special Medicare CoP	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.

	ate Share Hospital Payments to Evansville Psychiatric Children's Center						
A-05-12-00041	Indiana Improperly Claimed Federal Reimburseme nt for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Evansville State Hospital	6/30/2013	We recommend that the State Medicaid agency: refund $7,092,206 to the Federal Government for its share of inpatient psychiatric service payments made to Evansville for claims with dates of service when it did not demonstrate compliance with the special Medicare CoP	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00041	Indiana Improperly Claimed Federal Reimburseme nt for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Evansville State Hospital	6/30/2013	We recommend that the State Medicaid agency: ensure that Federal reimbursement for Medicaid inpatient psychiatric service payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the special Medicare CoP.	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00042	Indiana Improperly Claimed Federal Reimburseme nt for All Reviewed Medicaid Inpatient Psychiatric Hospital	2/8/2013	We recommend that the State agency refund $5,841,815 to the Federal Government for its share of inpatient psychiatric service payments made to Logansport for claims with dates of service when it did not demonstrate compliance with the special Medicare CoP	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.

	Service Payments to Logansport State Hospital						
A-05-12-00042	Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Logansport State Hospital	2/8/2013	We recommend that the State agency identify and refund the Federal share of any additional payments made to Logansport for claims with dates of service after the audit period if neither the State agency nor Logansport can demonstrate the hospital's compliance with Federal requirements for inpatient psychiatric hospital services	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00042	Indiana Improperly Claimed Federal Reimbursement for All Reviewed Medicaid Inpatient Psychiatric Hospital Service Payments to Logansport State Hospital	2/8/2013	We recommend that the State agency ensure that Federal reimbursement for Medicaid inpatient psychiatric service payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the special Medicare CoP.	Concur	2020	In Progress	The disallowance letter was issued to the state on 9/27/2019. CMS will close recommendation once recoupment is confirmed.
A-05-12-00046	Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the	3/16/2015	We recommend that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

	Skilled Nursing Facility Prospective Payment System Rates						
A-05-12-00050	Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children's Psychiatric Hospital	6/21/2013	We recommend that the State agency: refund $21,375,765 to the Federal Government for its share of Medicaid inpatient psychiatric service and DSH payments made to Hawthorn for claims with dates of service outside the regulatory gap period	Concur	2020	In Progress	CMS is in process of drafting the disallowance package
A-05-12-00050	Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children's Psychiatric Hospital	6/21/2013	We recommend that the State agency: work with CMS to determine whether the State agency should refund an additional $1,346,500 to the Federal Government for its share of payments made to Hawthorn for claims with dates of service during the regulatory gap period	Concur	2020	In Progress	CMS is in process of drafting the disallowance package

A-05-12-00050	Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children's Psychiatric Hospital	6/21/2013	We recommend that the State agency: identify and refund the Federal share of any additional payments made to Hawthorn for claims with dates of service after the audit period if neither the State agency nor Hawthorn can demonstrate the hospital's compliance with Federal requirements for inpatient psychiatric hospital services	Concur	2020	In Progress	CMS is in process of drafting the disallowance package
A-05-12-00050	Missouri Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Inpatient Psychiatric Hospital Service and Disproportionate Share Hospital Payments to Hawthorn Children's Psychiatric Hospital	6/21/2013	We recommend that the State agency: ensure that Federal reimbursement for Medicaid inpatient psychiatric service and DSH payments to psychiatric hospitals is claimed only if those hospitals can demonstrate compliance with the special Medicare CoP	Concur	2020	In Progress	CMS is in process of drafting the disallowance package
A-05-12-00053	CMS Should Improve Oversight for the Transfer of True Out-of-Pocket Costs Between Part D Plans	12/23/2013	We recommended that CMS implement controls to ensure the TrOOP facilitator initiates FIR transactions to transfer TrOOP balances from (1) plans providing services to non-enrollees and (2) previously rejected FIRs that have since been corrected.	Concur	2016	Awaiting Disposition	CMS considers this recommendation completed. Procedures are as follows: FIR transactions are automatically generated when a beneficiary is retroactively dis-enrolled through a non-plan of record process. For situations where the plan paid for the beneficiary, however there is no enrollment record, the plan can request a proxy add and a FIR will be generated for that beneficiary. Instructions for plans to follow are on the Transaction Facilitator's website which also includes the NCPDP Non Plan of Record whitepaper. https://medifacd.mckesson.com/fir/non-plan-of-record/

A-05-12-00055	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital	7/10/2014	We recommend that the State Medicaid agency: refund $17,395,647 to the Federal Government for its share of payments to Catawba for inpatient hospital services it provided to patients aged 65 or older on dates outside the regulatory gap period	Concur	2020	In Progress	The State made a line 10A adjustment on the 1Q19 CMS-64 returning the disallowed federal funds in the amount of $17,395,647. The appeal filed by the state is still before the DAB.
A-05-12-00055	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital	7/10/2014	We recommend that the State Medicaid agency: work with CMS to determine whether the State Medicaid agency should refund an additional $1,212,002 to the Federal Government for its share of payments to Catawba for inpatient hospital services it provided to patients aged 65 or older on dates during the regulatory gap period	Concur	2020	In Progress	The State made a line 10A adjustment on the 1Q19 CMS-64 returning the disallowed federal funds in the amount of $1,212,002. The appeal filed by the state is still before the DAB.
A-05-12-00055	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital	7/10/2014	We recommend that the State Medicaid agency: identify and refund the Federal share of any additional Medicaid payments to Catawba for inpatient hospital services it provided to patients aged 65 or older on dates after the audit period if neither the State Medicaid agency nor Catawba can demonstrate Catawba's compliance with Federal requirements for those services	Concur	2020	In Progress	The appeal filed by the state is still before the DAB.
A-05-12-00055	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital	7/10/2014	We recommend that the State Medicaid agency: ensure that it claims Federal reimbursement for Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs only if those IMDs can demonstrate compliance with the special Medicare CoP	Concur	2020	In Progress	The appeal filed by the state is still before the DAB.

A-05-12-00056	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Piedmont Geriatric Hospital	7/10/2014	We recommend that the State Medicaid agency: refund $36,903,169 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates outside the regulatory gap period	Concur	2020	In Progress	The State made a line 10A adjustment on the 1Q19 CMS-64 returning the disallowed federal funds in the amount of $36,903,169. The appeal filed by the state is still before the DAB.
A-05-12-00056	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Piedmont Geriatric Hospital	7/10/2014	We recommend that the State Medicaid agency: work with CMS to determine whether the State Medicaid agency should refund an additional $2,462,157 to the Federal Government for its share of payments to Piedmont for inpatient hospital services it provided to patients aged 65 or older on dates during the regulatory gap period	Concur	2020	In Progress	The State made a line 10A adjustment on the 1Q19 CMS-64 returning the disallowed federal funds in the amount of $2,462,157. The appeal filed by the state is still before the DAB.
A-05-12-00056	Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Piedmont Geriatric Hospital	7/10/2014	We recommend that the State Medicaid agency: ensure that it claims Federal reimbursement for Medicaid payments for inpatient hospital services provided to patients aged 65 or older in IMDs only if those IMDs can demonstrate compliance with the special Medicare CoP	Concur	2020	In Progress	The appeal filed by the state is still before the DAB.
A-05-12-00086	CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries	9/5/2014	To improve protection provided to Medicaid hospice beneficiaries, we recommend that CMS work with the State agency and the Ohio Department of Health to ensure that hospices meet the State licensure requirements for hospice workers.	Concur	2020	Awaiting Disposition	CMS does not have the authority to enforce or direct State policies. Once this last contact is made the corrective action plan should be considered complete. Additional conversations between the RO and the state are expected by the end of winter.

A-05-13-00024	Medicare Contractors Nationwide Overpaid Millions to Providers for Full Vials of Herceptin	11/27/2013	We recommended that CMS review other multiuse-vial drugs to determine whether system edits are needed to prevent incorrect billings.	Non-concur	NA	Awaiting Disposition	CMS non concur position has not changed, no action taken due to non concur with recommendation.
A-05-13-00043	Ohio Made Incorrect Medicaid Electronic Health Record Incentive Payments	8/30/2013	We recommend that the State agency review the payment calculations for the 100 hospitals not included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified.	Concur	2019	Awaiting Disposition	Ohio returned $2,051,366 on the QE 03/31/19 CMS 64 as identified overpayments after finalized settled cost reports were available. CMS believes Ohio has addressed this finding and returned all overpayments related to this finding. CMS believes this finding is closed.
A-05-13-00043	Ohio Made Incorrect Medicaid Electronic Health Record Incentive Payments	8/30/2013	We recommend that the State agency review remaining payment calculations for the hospitals included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified.	Concur	2019	Awaiting Disposition	Ohio returned $1,930,086 on the QE 12/31/18 CMS 64 as identified overpayments after finalized settled cost reports were available. CMS believes Ohio has addressed this finding and returned all overpayments related to this finding. CMS believes this finding is closed.
A-05-13-00045	Wisconsin Inappropriately Withdrew Federal Medicaid Funds for Fiscal Years 2010 Through 2012	10/15/2015	We recommend that the State agency refund $89,624,201 to the Federal Government.	Concur	2017	Awaiting Disposition	CMS reviewed the State's documentation supporting the questioned amounts claimed and have determined that it accurately supports the return of funds. CMS considers this issue closed.
A-05-13-00046	Illinois Improperly Claimed Medicaid Reimbursement for Optical Services and Supplies	6/4/2015	We recommend that the State agency refund $488,456 to the Federal Government.	Concur	2020	In Progress	CMS is working on the disallowance package.
A-05-14-00041	Many Medicare Claims for Outpatient	3/14/2018	We recommended that CMS establish mechanisms to better monitor the appropriateness of	Non-Concur	2020	In Progress	CMS will instruct the SMRC to review outpatient physical therapy claims, incorporating these reviews into our statutorily mandated MACRA reviews.

	Physical Therapy Services Did Not Comply With Medicare Requirements		outpatient physical therapy claims.				
A-05-14-00045	The Minnesota Marketplace Misallocated Federal Funds and Claimed Unallowable Costs	11/23/2016	refund to CMS $933,582 consisting of (1) $929,582 that was paid for additional marketing work performed without a contract amendment	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-05-14-00045	The Minnesota Marketplace Misallocated Federal Funds and Claimed Unallowable Costs	11/23/2016	create a complete and accurate inventory record, develop procedures to ensure that it maintains complete and accurate inventory records for equipment purchased with establishment grant funds, and conduct a physical inventory at least biennially.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-05-14-00045	The Minnesota Marketplace Misallocated Federal Funds and Claimed Unallowable Costs	11/23/2016	strengthen senior management oversight to ensure that additional contract work is not performed before an amendment is in place	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-05-14-00047	Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements	6/7/2017	We recommend that CMS recover $291,222 in payments made to the sampled Eligible Professionals who did not meet meaningful use requirements.	Concur	2019	Awaiting Disposition	Closed 10/30/19
A-05-14-00047	Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments	6/7/2017	We recommend that CMS recover $2,344,680 in overpayments made to Eligible Professionals after they switched programs.	Concur	2020	In Progress	Actions to recover the remaining balance will continue in conformance with CMS' collection process.

	That Did Not Comply With Federal Requirements						
A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program	11/15/2017	We recommend that CMS ensure that suppliers have the applicable licenses for the specific competitions in which they are submitting a bid by continuing to work with State licensing boards, as recommended in our previous report.	Concur	2020	In Progress	Procure a contract under the PEOG-IDIQ to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process.
A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program	11/15/2017	We recommend that CMS monitor supplier licensure requirements by implementing a system to identify and address potential unlicensed suppliers.	Concur	2021	In Progress	Procure a contract under the PEOG-IDIQ to continuously monitor DMEPOS suppliers to ensure they maintain an active license throughout the competitive bid and enrollment process.
A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program	11/15/2017	We recommend that CMS follow its established program procedures and applicable Federal requirements consistently in evaluating the financial documents of all suppliers.	Concur	2020	Awaiting Disposition	CMS received the data on the suppliers OIG identified as not meeting financial standards. CMS reviewed the data and, except for one of the suppliers, we believe the CMS/CBIC correctly followed our evaluation process. Following up with OIG for closure.
A-05-15-00020	Medicare Could Save Millions by Eliminating the Lump-Sum Purchase Option for All Power Mobility Devices	5/17/2017	We recommend that CMS seek legislation to eliminate the lump-sum payment option for all PMDs. If such legislation had been in place during CYs 2011 through 2014, Medicare could have saved at least an additional $10,245,539.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
A-05-15-00035	Indiana Made Incorrect Medicaid Payments to Providers for Full Vials of Herceptin	5/16/2016	We recommend that the State agency implement or update system edits that identify for review multiuse-vial drugs that are billed with units of service equivalent to the dosage of an entire vial(s).	Concur	2020	In Progress	The State has indicated it is still working toward the CAP. CMS continues to work with the State to ensure CAP is implemented.

A-05-15-00040	Review of Wisconsin Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	6/6/2017	We recommend that the State agency incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule.	Concur	2020	In Progress	Because the federal managed care regulations do not require states to institute a remittance provision and the contract language was amended to include required MLR language there is no further compliance action pending related to Badger Care and SSI Managed Care. In regards to Children Come First and Wraparound Milwaukee, CMS is still pending receipt of a contract amendment which includes language concerning the MLR provisions. The state plans to submit an amendment in November or December 2019. It is the CMS's understanding that the state will not institute a remittance provision for this program as part of the amendment.
A-05-16-00021	Michigan Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Brokerage Program	6/14/2018	We recommend that the State agency improve its oversight and monitoring of its Medicaid NEMT brokerage program by requiring LogistiCare to strengthen its procedures to ensure that (1) NEMT services are adequately documented and the documentation maintained according to Federal and State regulations; (2) transportation provider qualifications meet State requirements; and (3) vehicle inspection, safety, and insurance requirements are met.	Concur	2020	In Progress	The State is requiring Logisticare to return the federal portion of the questioned costs. The state will then recoup these funds and report them on the 12312019 CMS 64
A-05-16-00021	Michigan Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Brokerage Program	6/14/2018	We recommend that the State agency strengthen its controls over its process for reporting expenditures claimed for NEMT services.	Concur	2020	In Progress	The state has submitted an RFP for review by CMS. The contract has not been fully executed yet, however the language in the RFP is the basis of the actual contract. Anticipated completion date is 02/28/2020.
A-05-16-00021	Michigan Did Not Always Comply With Federal and State Requirements for Claims Submitted for	6/14/2018	We recommend that the State agency refund $4,503,738 to the Federal Government	Concur	2020	In Progress	The state has submitted an RFP for review by CMS. The contract has not been fully executed yet, however the language in the RFP is the basis of the actual contract. Anticipated completion date is 02/28/2020.

	the Nonemergency Medical Transportation Brokerage Program						
[A-05-16-00021]()	Michigan Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Brokerage Program	6/14/2018	We recommend that the State agency ensure that the State agency's contract with the transportation broker contains provisions that (1) consider improper claims submitted by transportation providers to the transportation broker when developing future capitated rates paid by the State agency and (2) provide a means for the State agency to recoup funds from the transportation broker when contract provisions and State requirements are not met—a measure that, if incorporated, could result in cost savings for the Medicaid program.	Concur	2020	In Progress	The state has submitted an RFP for review by CMS. The contract has not been fully executed yet, however the language in the RFP is the basis of the actual contract. Anticipated completion date is 02/28/2020.
[A-05-16-00044]()	Minnesota Did Not Comply With Federal Waiver and State Requirements for 18 of 20 Family Adult Foster Care Homes Reviewed	10/31/2017	We recommend that the State agency ensure that the 64 instances of noncompliance with health and safety and administrative requirements identified in this report are corrected.	Concur	2019	Awaiting Disposition	Minnesota provided CMS with documentation showing that DHS contacted each county that had items of non-compliance identified in the report and consulted with the licensor regarding the appropriate action that was taken for each item. DHS worked with the licensor until all items of non-compliance were corrected. The counties involved, licensor, license holder, and each item of noncompliance were detailed in a document titled Audit Response – AFC Recommendation 1 that CMS used to ensure all issues of non-compliance were addressed. CMS believes Minnesota has properly addressed this audit recommendation and considers the finding to be closed.
[A-05-16-00044]()	Minnesota Did Not Comply With Federal Waiver and State Requirements for 18 of 20 Family Adult Foster Care	10/31/2017	We recommend that the State agency work with counties to ensure the health and safety of vulnerable adults by considering staffing standards and caseload thresholds for county agencies.	Concur	2019	Awaiting Disposition	The questions for the survey were developed and a DHS licensing staff employee was trained to use the DHS approved survey tool. In addition to the new survey tool, the monitoring tools DHS uses when completing Rule 13 reviews at the county agencies added additional questions. CMS believes with the Implementation of the survey tool and also the additional questions when completing Rule 13 reviews at the county, that Minnesota has properly addressed the Recommendation for this audit and will use these tools in determining staffing standards and caseload thresholds at the county agencies. CMS believes this finding to be closed.

	Homes Reviewed						
A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements	4/5/2018	We recommend that CMS take the following actions, which we estimate could have saved approximately $3,699,848 for calendar years 2014 and 2015: conduct periodic postpayment reviews to disallow payments for errors for which telehealth claim edits cannot be implemented (for example, unallowable originating sites or unallowable means of communication).	Concur	2020	In Progress	CMS submitting OCD for OIG closure consideration. As part of the Comprehensive Error Rate Testing Program, which CMS uses to calculate the annual improper payment rate in the Medicare Fee-For- Service program, CMS reviews a sample of telehealth claims. As part of this process, medical review professionals perform complex medical review of documentation submitted to support the claim to determine whether the claim was paid properly under Medicare coverage, coding, and billing rules.
A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements	4/5/2018	We recommend that CMS take the following actions, which we estimated could have saved approximately $3,699,848 for calendar years 2014 and 2015: work with Medicare contractors to implement all telehealth claims edits listed in the Manual	Concur	2020	Awaiting Disposition	The CR for revisions to the Telehealth Billing Requirements for Distant Site Services has been issued and was effective 10/1/18. CMS requested OIG closure 2019.
A-05-16-00058	CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements	4/5/2018	We recommend that CMS take the following actions, which we estimate could have saved approximately $3,699,848 for calendar years 2014 and 2015: offer education and training sessions to practitioners on Medicare telehealth requirements and related resources.	Concur	2020	In progress	We're in process of determining and finalizing the appropriate type/level of provider education needed, and are on schedule to meet the target completion date of July 31, 2019.

A-05-16-00059	Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits	3/8/2018	We recommended that CMS assuming the OIG recommendation requiring the use of condition codes 49 and 50 is implemented, instruct its Medicare contractors to implement a post-payment process to follow up with any hospital that submits a claim for certain cardiac device replacement procedures (see Appendix C) with condition code 49 or 50 but no value code FD to determine whether an adjustment claim should be submitted.	Non-Concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
A-05-16-00059	Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits	3/8/2018	We recommended CMS consider studying alternatives to implementing edits in order to eliminate the current Medicare requirements for reporting device credits, for instance, by reducing IPPS and OPPS payments for device-intensive procedures.	Concur	2021	In Progress	Working internally with the leadership to finalize course of action.
A-05-16-00062	Medicare Compliance Review of Rush University Medical Center,	11/6/2017	We recommend that the Hospital exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.	Concur	2020	In Progress	On August 12, 2019, CMS received notification from the provider that the provider performed a self-audit and is working through a settlement agreement with the U.S. Attorney's Office for the Northern District of Illinois. The settlement agreement is in the final stages of negotiation.
A-05-16-00064	Medicare Compliance Review of The University of Michigan Health System	1/23/2018	We recommend that the Hospital exercise reasonable diligence to identify and return any additional similar overpayments received outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.	Concur	2020	In Progress	CMS is working with the provider and the MAC to identify and finalize all claims adjustments.

A-05-17-00009	Minnesota Did Not Comply With Federal Waiver and State Requirements for All 20 Adult Day Care Centers Reviewed	5/30/2018	We recommend that the State agency consider developing templates for administrative records the State requires.	Concur	2019	Awaiting Disposition	CMS has confirmed that the state has developed templates in the Fall of 2018. CMS has verified these templates and the state has provided documentation for administrative records as recommended. We believe these templates adequately address this finding. A sample of these templates are on file. CMS considers this recommendation closed.
A-05-17-00009	Minnesota Did Not Comply With Federal Waiver and State Requirements for All 20 Adult Day Care Centers Reviewed	5/30/2018	We recommend that the State agency ensure that the 200 instances of noncompliance with health and safety and administrative requirements identified in this report are corrected.	Concur	2020	In Progress	CMS continues to follow up with the State regarding the status of the recommendation
A-05-17-00009	Minnesota Did Not Comply With Federal Waiver and State Requirements for All 20 Adult Day Care Centers Reviewed	5/30/2018	We recommend that the State agency ensure the health and safety of vulnerable adults by considering staffing standards and caseload thresholds for State licensors.	Concur	2020	In Progress	CMS continues to follow up with the State regarding the status of the recommendation
A-06-09-00062	Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health	3/12/2012	We recommend that the State agency refund to the Federal Government the $888,683 paid to Ambercare for unallowable personal care services.	Concur	2020	In Progress	Disallowance package under review by CMS Central Office.
A-06-09-00063	Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare	5/15/2012	We recommend that the State agency refund to the Federal Government the $4,483,492 paid to Heritage for unallowable personal care services.	Concur	2020	In Progress	Disallowance package under review by CMS Central Office.

A-06-09-00064	Review of New Mexico Medicaid Personal Care Services Provided by Coordinated Home Health	9/11/2012	We recommend that the State agency refund to the Federal Government the $10,962,174 paid to Coordinated for unallowable personal care services.	Concur	2020	In Progress	Disallowance package under review by CMS Central Office.
A-06-09-00117	Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc	6/15/2012	We recommend that the State agency refund to the Federal Government the $404,817 paid to Clovis for unallowable personal care services.	Concur	2020	In Progress	Disallowance package under review by CMS Central Office.
A-06-11-00022	Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010	1/18/2013	We recommend that the State agency review the claim-level data of quarters that we did not analyze, identify infant delivery costs incorrectly classified as family planning expenditures as a result of the programming errors, and refund overpayments to the Federal Government.	Concur	2019	Awaiting Disposition	The state completed an internal review which determined the date that the process was discontinued which caused the audit error. The state advised that based on the documentation reviewed, this family planning reclassification was made through FFY 2017 Quarter 4 filing of the CMS-64. The state then went back four quarters prior to make the applicable adjustments. In total, the state returned $703,990 FFP on the Q1 FY19 CMS-64 report as Line 10A adjustments based on their review. CMS is satisfied with the state's resolution of this finding. CMS considers this finding closed.
A-06-11-00048	Texas Paid Millions for Unallowable Medicaid Orthodontic Services	6/3/2015	We recommended that the State agency determine and refund the Federal share of any additional amounts related to orthodontic prior authorizations that the State agency improperly claimed after our audit period.	Concur	2020	In Progress	The state provided the claims that CMS requested and the OIG is currently reviewing them with CMS
A-06-12-00038	Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs	9/15/2014	We recommend that CMS amend current regulations to decrease the Part B payment rates for dispensing and supplying fees to rates similar to those of other payers, such as Part D and Medicaid.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.

A-06-12-00053	Texas Did Not Always Comply with Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program	10/20/2014	We recommend that the State agency refund $30,385,925 to the Federal Government.	Concur	2020	In Progress	Disallowance package under review by CMS Central Office.
A-06-14-00002	Texas Improperly Received Medicaid Reimbursement for School-Based Health Services	8/14/2017	We recommended that the State agency refund to the Federal Government the $18,925,853 Federal share of unallowable reimbursement that was claimed for the Medicaid SHARS program because the random moments were coded incorrectly.	Concur	2020	In Progress	The $18,122,936 disallowance package is under review by CMS Central Office.
A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	We recommend that CMS require States to reconcile total Federal Medicaid funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines.	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements
A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	We recommend that CMS issue guidance that clarifies existing requirements and provides further interpretation of the "as needed" language in 42 CFR § 430.30(d)(3) as it relates to the withdrawal of Medicaid funds	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements
A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	We recommend that CMS publish and enforce formal guidance based on the November 8, 2011, email, so that States are aware of the appropriate PMS account from which to withdraw or return fund	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements

A-06-14-00068	Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds	3/29/2016	We recommend that CMS publish regulations that are consistent with the Treasury provisions in 31 CFR part 205 and educate States.	Concur	2020	In Progress	CMS is in the process of drafting guidance to clarify existing requirements
A-06-14-00074	Medicare Compliance Review of Houston Methodist Hospital for 2012 and 2013	7/7/2016	We recommend that the Hospital refund to the Medicare contractor $579,799 in estimated net overpayments for claims that were incorrectly billed during the 3-year recovery period.	Concur	2020	In Progress	After appeal to QIC, the overpayment was reduced to $546,347. The provider has appealed the remaining overpayment to the ALJ.
A-06-14-00074	Medicare Compliance Review of Houston Methodist Hospital for 2012 and 2013	7/7/2016	We recommend that the Hospital work with the Medicare contractor to return overpayments that were made outside of the 3-year recovery period, which we estimate to be as much as $619,350 for our audit period, in accordance with the 60-day repayment rule.	Concur	2020	In Progress	The Hospital has not identified overpayments from this recommendation as they believe the OIG's estimate will be reduced based on the appeals decisions of the claims identified in the audit report.
A-06-15-00014	Medicare Contractor Payments to Providers for Hospital Outpatient Dental Services in Jurisdiction H Generally Did Not Comply With Medicare Requirements	4/7/2016	We recommend that Novitas recover the $1,767,106 in unallowable payments.	Concur	2020	In Progress	After appeal to QIC, the overpayment was reduced to $341,715 . The provider has appealed the remaining overpayment to the ALJ.
A-06-15-00041	Texas Did Not Appropriately Spend Some State Balancing Incentive Payments Program Funds	12/28/2017	We recommend that the State agency refund $11,982,826 in BIPP funds.	Concur	2020	In Progress	CMS is working on an amended OCD to reflect the amount collected from the State.

A-06-15-00045	Texas Did Not Make Increased Primary Care Provider Payments and Claim Reimbursement in Accordance with Federal Requirements	4/4/2018	We recommend that Texas work with the Centers for Medicare & Medicaid Services to determine the portion of the $1.1 million that it received for payments that exceeded providers' billed charges should be refunded to the Federal Government.	Concur	2020	In Progress	CMS continues to work with the State on the submittal of supporting data to support that the FFP is allowable.
A-06-15-00045	Texas Did Not Make Increased Primary Care Provider Payments and Claim Reimbursement in Accordance with Federal Requirements	4/4/2018	We recommend that Texas refund $20.7 million to the Federal Government that it received for incorrectly claimed and unallowable payments.	Concur	2020	In Progress	CMS continues to work with the state and the OIG to recover and return the appropriate funds associated with the finding.
A-06-15-00057	Public Summary Report: Information Technology Control Weaknesses Found at the Commonwealth of Massachusetts' Medicaid Management Information System	2/10/2017	We recommend that MassHealth implement adequate information system general controls over its MMIS. Specifically, we recommend that MassHealth: develop and implement mechanisms to encrypt all claims processing databases that contain Medicaid information in accordance with Federal requirements.	Concur	2021	In Progress	The Commonwealth is in the process of deploying Windows 10 to all machines in the EHS (and Commonwealth) environment. The Commonwealth expressed a requirement to EOTSS that all EOHHS computers are encrypted by default with Bitlocker. The Windows deployment is slated to be a 78 week project for now and could be longer.
A-06-15-00057	Public Summary Report: Information Technology Control Weaknesses Found at the Commonwealth of Massachusetts'	2/10/2017	We recommend that MassHealth implement adequate information system general controls over its MMIS. Specifically, we recommend that MassHealth: develop and implement procedures to detect and prevent the use of unauthorized and/or unnecessary wireless access points.	Concur	2019	Awaiting Disposition	CMS reviewed the Commonwealth's written policies and procedures for risk assessments and determined it describes what the Commonwealth does to detect and prevent unauthorized/unnecessary wireless access points. CMS considers this recommendation closed.

	Medicaid Management Information System						
A-06-15-00057	Public Summary Report: Information Technology Control Weaknesses Found at the Commonwealth of Massachusetts' Medicaid Management Information System	2/10/2017	We recommend that MassHealth implement adequate information system general controls over its MMIS. Specifically, we recommend that MassHealth: ensure that all vulnerabilities identified during vulnerability scanning are prioritized and remediated in accordance with Federal requirements.	Concur	2019	Awaiting Disposition	CMS reviewed the Commonwealth's written policies and procedures for risk assessments and determined it describes vulnerability scanning. CMS considers this recommendation closed.
A-07-08-03107	Review of Missouri Medicaid Payments for the School District Administrative Claiming Program for Federal Fiscal Years 2004 Through 2006	3/18/2010	We recommended that the State agency refund $20,469,670 ($4,212,506 for the St. Louis Public and Springfield school districts and $16,257,164 for the other Missouri school districts) to the Federal Government for unallowable School District Administrative Claiming (SDAC) program expenditures.	Concur	2020	In Progress	The State agency has returned $575,037 via CMS-64 adjustments. CMS is in process of drafting the disallowance package for the remaining amount.
A-07-11-03171	Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims	9/24/2012	We recommend that the State agency refund $26,953,855 to the Federal Government. As of 2/3/2014 the recommended refund amount was revised to $23,320,626 based on additional documentation provided by MO.	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.

A-07-12-01113	Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2009 Through 2011	1/23/2013	We recommend that CMS work with the Medicare contractors to ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
A-07-12-06038	Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011	10/30/2013	We recommend that CMS develop and implement controls to ensure that Medicare does not pay for prescription drugs for unlawfully present beneficiaries by preventing enrollment of unlawful beneficiaries, disenrolling any currently enrolled unlawful beneficiaries, and automatically rejecting PDE records submitted by sponsors for prescription drugs provided to this population.	Concur	2021	In progress	CMS is currently negotiating a data exchange agreement with SSA to obtain the data necessary to implement a mechanism to relay lawful presence status to plans.
A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012	4/23/2014	We recommend that CMS implement policies and procedures, consistent with those in effect under its FFS program, to notify MA organizations of unlawful-presence information and thereby prevent enrollment in MA organizations, disenroll beneficiaries already enrolled, and recoup any improper payments.	Concur	2020	Awaiting Disposition	CMS has finalized and promulgated regulations and guidance. CMS developed a Computer Matching Agreement (CMA) to use data from Social Security Administration (SSA). In consultation from the HHS Data Integrity Board and OGC, CMS has moved from the development and clearance of a CMA to a more efficient data use agreement namely, an Information Exchange Agreement (IEA.)This agreement will reduce current and future administrative burden for both CMS and the SSA and promote more efficient exchange of the data. The draft agreement is under review and clearance with the CMS privacy office. CMS anticipates that the agreement will be shared and executed with the SSA within 6 months. Completion of systems changes are dependent upon finalization of the data use agreement.

A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012	4/23/2014	We recommend that CMS identify and recoup improper payments made to MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented that would ensure Medicare no longer pays for unlawful beneficiaries.	Concur	2020	Awaiting Disposition	CMS has finalized and promulgated regulations and guidance. CMS developed a Computer Matching Agreement (CMA) to use data from Social Security Administration (SSA). In consultation from the HHS Data Integrity Board and OGC, CMS has moved from the development and clearance of a CMA to a more efficient data use agreement namely, an Information Exchange Agreement (IEA.)This agreement will reduce current and future administrative burden for both CMS and the SSA and promote more efficient exchange of the data. The draft agreement is under review and clearance with the CMS privacy office. CMS anticipates that the agreement will be shared and executed with the SSA within 6 months. Completion of systems changes are dependent upon finalization of the data use agreement.
A-07-13-01125	Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012	4/23/2014	We recommend that CMS recoup the $26,150,043 in improper payments in accordance with legal requirements.	Non-concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any further action.
A-07-13-01127	Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012	4/7/2014	We recommend that CMS implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to entitlement-terminated beneficiaries in cases when entitlement termination information is received on previously paid Medicare claims.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
A-07-13-01127	Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012	4/7/2014	We recommend that CMS identify improper payments made on behalf of entitlement-terminated beneficiaries after our audit period but before implementation of policies and procedures and ensure that Medicare contractors recoup those improper payments.	Concur	2020	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.

A-07-13-03193	Missouri Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Developmental Disabilities	10/30/2014	We recommend that the State agency refund $11,464,069 to the Federal Government, adjust future payment rates for TCM services and work with the Centers for Medicare & Medicaid Services to determine the unallowable Medicaid payments that should be refunded to the Federal Government, and follow the State plan requirements for the calculation of rebased payment rates for TCM services.	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.
A-07-13-03193	Missouri Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Developmental Disabilities	10/30/2014	We recommend that the State agency adjust future payment rates for TCM services and work with the Centers for Medicare & Medicaid Services to determine the unallowable Medicaid payments that should be refunded to the Federal Government.	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.
A-07-13-04207	Kansas Improperly Received Medicaid Reimbursement for School-Based Health Services	8/6/2014	We recommend that the State agency strengthen policies and procedures to monitor the SBHS program and ensure that (1) SBHS costs are accurate and supported and (2) it claims all SBHS costs in accordance with applicable Federal and State requirements.	Concur	2020	In Progress	CMS is reviewing updated policies are procedures submitted by the State agency.
A-07-13-06046	Nebraska Did Not Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	12/22/2017	We recommend that the State agency complete the process of developing and implementing policies and procedures to ensure that all physician-administered drugs dispensed to enrollees of MCOs and eligible for rebates are invoiced.	Concur	2020	In Progress	CMS is working with the State agency to obtain updated policies and procedures.

A-07-13-06046	Nebraska Did Not Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	12/22/2017	We recommend that the State agency refund to the Federal Government $1,065,264 (Federal share) for rebates for physician administered drugs dispensed to enrollees of MCOs that were not invoiced to manufacturers.	Concur	2020	In Progress	CMS is working with the state to recover the overpayment.
A-07-13-06046	Nebraska Did Not Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	12/22/2017	We recommend that the State agency work with CMS to determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not invoiced for rebates after December 31, 2013.	Concur	2020	In Progress	CMS is working with the state to recover any additional overpayments
A-07-14-03201	Missouri Claimed Unallowable and Unsupported Medicaid Payments for Group Home Habilitation Services	8/12/2015	We recommend that the State agency refund $3,034,157 to the Federal Government,	Concur	2020	In Progress	CMS is drafting a disallowance package.
A-07-14-03202	Missouri Claimed Unallowable Medicaid Payments for Individualized Supported Living Habilitation Services	3/17/2016	We recommend that the State agency refund $1,455,378 to the Federal Government	Concur	2020	In Progress	CMS issued a disallowance on 7/31/19 and is awaiting notification as to whether the State agency intends to appeal to the DAB.
A-07-14-06050	Colorado Claimed Unallowable Federal Reimburseme nt for Some	1/5/2017	We recommend that the State agency strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.	Concur	2020	In Progress	CMS is working with the State agency to obtain updated policies and procedures.

	Medicaid Physician-Administered Drugs						
A-07-14-06051	Missouri Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	4/13/2015	We recommend that the State agency work with CMS to determine and refund the unallowable Federal reimbursement for physician-administered drugs claimed without NDCs and not billed for rebates after December 31, 2011	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.
A-07-14-06051	Missouri Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	4/13/2015	We recommend that the State agency refund to the Federal Government $34,181,807 (Federal share) for claims for single-source physician-administered drugs that were ineligible for Federal reimbursement	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.
A-07-14-06051	Missouri Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	4/13/2015	We recommend that the State agency refund to the Federal Government $656,150 (Federal share) for claims for top-20 multiple-source physician-administered drugs that were ineligible for Federal reimbursement.	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.
A-07-14-06051	Missouri Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	4/13/2015	We recommend that the State agency work with CMS to determine the unallowable portion of the $13,225,151 (Federal share) for other claims for outpatient physician-administered drugs that were ineligible for Federal reimbursement and refund that amount,	Concur	2020	In Progress	The disallowance package is under review in CMS Central Office.

A-07-16-03209	Nebraska Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Transportation Program	3/1/2017	We recommend that the State agency refund to the Federal Government $1,911,138 (Federal share) in estimated overpayments for NET claims that were in error and did not comply with Federal and State requirements.	Concur	2020	In Progress	CMS is working with the State and OIG to review 17 claims to determine eligibility
A-07-16-03209	Nebraska Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Transportation Program	3/1/2017	We recommend that the State agency strengthen its policies and procedures to ensure that: transportation services are provided only to recipients who are receiving Medicaid-covered services on the dates that they are receiving NET services; NET providers maintain records documenting that recipients are actually transported in the vehicles for all trips on the dates that NET services are rendered; NET providers maintain records to document the services provided; it does not pay NET providers or claim Federal reimbursement for non-covered transportation services; NET providers complete the required background checks on all potential drivers before permitting them to render NET services and annually thereafter, and maintain documentation of these checks; NET providers maintain records of all vehicle maintenance checks; and NET providers maintain documentation verifying that their drivers are qualified with current and valid driver's licenses.	Concur	2020	In Progress	The State agency switched NEMT to managed care. CMS requested that the state still provide evidence of oversight functions or efforts in monitoring the program.

A-07-16-03215	Colorado Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services	4/14/2018	We recommend that the State agency refund $2,160,743 to the Federal Government for unallowable TCM claims.	Concur	2019	Awaiting Disposition	The State agency returned $2,160,743 on the QE 03/31/19 CMS-64. CMS considers this finding closed.
A-07-16-03215	Colorado Claimed Some Unallowable Medicaid Payments for Targeted Case Management Services	4/14/2018	We recommend that the State agency strengthen its policies and procedures to ensure that TCM providers maintain documentation to document that case managers are qualified to perform TCM services, TCM providers maintain documentation to support the TCM services provided, it does not pay TCM providers or claim Federal reimbursement for services that are not TCM services, and TCM providers maintain documentation for eligibility determinations for recipients of TCM services.	Concur	2020	In Progress	CMS has requested additional documentation from the State agency to verify corrective action.
A-07-16-04229	Wisconsin Physicians Service Insurance Corporation Did Not Properly Settle Missouri Medicare Disproportion ate Share Hospital Payments	6/20/2017	We recommend that WPS reopen and revise final cost report settlements for those Medicare cost reports (from Missouri providers) that we did not review, recover any additional Medicare DSH overpayments made to Missouri providers, and refund those recovered amounts to the Federal Government.	Concur	2020	In Progress	WPS has conducted some reviews that resulted in collections of $1.6 million. Based on those reviews WPS is evaluating the cost/benefit of performing additional reviews.
A-07-17-02808	The Colorado Health Insurance Marketplace's Financial Management System Did Not Always Comply With	7/9/2018	refund to the Federal Government $1,998,617 in costs that were improperly transferred between grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

	Federal Requirements						
A-07-17-02808	The Colorado Health Insurance Marketplace's Financial Management System Did Not Always Comply With Federal Requirements	7/9/2018	Refund $568,987 in payments that were related to obligations that were not incurred during the grant funding period;	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-07-17-02808	The Colorado Health Insurance Marketplace's Financial Management System Did Not Always Comply With Federal Requirements	7/9/2018	work with CMS to certify the cost transfers associated with the remaining 352 expenditures totaling $3,177,310, ensure that each expenditure transferred was allowable, and refund any unallowable expenditures to the Federal Government	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-07-17-02808	The Colorado Health Insurance Marketplace's Financial Management System Did Not Always Comply With Federal Requirements	7/9/2018	develop and implement written policies and procedures to ensure that it administers its financial management system accurately and reliably and to ensure that for any future Federal grant awards, the marketplace's financial management system maintains effective control over and accountability for grant funds.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-07-17-03221	Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	5/14/2018	We recommend that the State agency revise its claims processing system edits to ensure that the payment reduction applies only to PPCs by including only those diagnosis codes that are included in the list of Medicare hospital-acquired conditions and that are considered a CC or MCCs.	Concur	2019	Awaiting Disposition	CMS determined the finding relates to older pricing methodology. Since Iowa is using new DRG methodology, this finding is no longer applicable. The finding is self correcting using the new DRG codes. CMS considers this finding closed.
A-07-17-03221	Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	5/14/2018	We recommend that the State agency obtain the POA codes for inpatient hospital types that were excluded due to the State agency's misinterpretation of the Federal requirements and identify and adjust any paid claims that were subject to payment reduction as a result of treating a PPC.	Concur	2019	Awaiting Disposition	CMS determined there are no claims to reprocess as the entities were cost settled for the cost report periods impacted by the exemption. CMS considers the finding closed.
A-07-17-03221	Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	5/14/2018	We recommend that the State agency identify any paid claims that had an improper payment reduction from diagnosis codes that were not considered a CC or MCC and make the proper adjustments.	Concur	2020	In Progress	CMS has requested additional documentation from the State agency to verify corrective action.

A-07-17-03221	Iowa Complied With Most Federal Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	5/14/2018	We recommend that the State agency issue a revised Informational Letter to require that all inpatient hospital types, including critical access hospitals, children's inpatient facilities, Indian Health Service facilities, and Veterans Administration and Department of Defense hospitals, report PPCs and appropriately reduce payments for PPCs for all future claims in accordance with Federal requirements.	Concur	2020	In Progress	CMS has requested additional documentation from the State agency to verify corrective action.
A-07-18-00535	First Coast Service Options, Inc., Overstated Medicare's Share of the Medicare Segment Excess Pension Liabilities	9/11/2018	We recommend that FCSO decrease Medicare's share of Medicare segment excess pension liabilities as of 12/31/10 by $6,629,592 and recognize $3,685,907 as Medicare's share of Medicare segment excess pension liabilities as a result of the benefit curtailment.	Concur	2020	In Progress	CMS is awaiting the resolution of the appeal filed by FCSO.
A-09-11-02016	California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers	4/15/2013	We recommend that the State agency refund $1,170,497 for unallowable Medicaid payments for items and services furnished, ordered, or prescribed by excluded providers	Concur	2020	In Progress	CMS is working with the State to review supporting documentation and determine the amount to be returned.
A-09-11-02016	California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers	4/15/2013	We recommend that the State agency ensure that payments are not made for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to determine whether any providers (i.e., furnishing, ordering, or prescribing) listed on claims	Concur	2020	In Progress	CMS is working with the State agency to obtain and review supporting documentation.

			are excluded and deny those claims.				
A-09-11-02016	California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers	4/15/2013	We recommend that the State agency ensure that payments are not made for items or services furnished, ordered, or prescribed by excluded providers by developing and implementing policies and procedures to monitor agencies that enroll providers or process Medicaid claims to ensure compliance with CMS guidance that reviews be conducted monthly to identify excluded providers	Concur	2020	In Progress	CMS is working with the State agency to obtain and review supporting documentation.
A-09-11-02016	California Made Unallowable Medicaid Payments for Items and Services Furnished, Ordered, or Prescribed by Excluded Providers	4/15/2013	We recommend that the State agency work with CMS to resolve the $698,756 set aside and refund any payments for items or services furnished, ordered, or prescribed by excluded providers	Concur	2020	In Progress	CMS is working with the State agency to obtain and review supporting documentation.
A-09-13-02001	California Withdrew Excessive Federal Medicaid Funds for Fiscal Year 2010	12/17/2015	We recommend that the State agency ensure that it obtains funds only for net expenditures reported on the CMS-64s.	Concur	2020	In Progress	CMS continues to work with the State agency to verify corrective action.

A-09-13-02001	California Withdrew Excessive Federal Medicaid Funds for Fiscal Year 2010	12/17/2015	We recommend that the State agency ensure that it can support the amounts it withdraws from its Payment Management System accounts and reports as adjustments on the CMS-64s.	Concur	2020	In Progress	CMS continues to work with the State agency to verify corrective action.
A-09-13-02001	California Withdrew Excessive Federal Medicaid Funds for Fiscal Year 2010	12/17/2015	We recommend that the State agency implement policies and procedures to resolve differences between the amounts awarded and obtained and the expenditures reported on the CMS-64s when reconciling its Payment Management System accounts.	Concur	2020	In Progress	CMS continues to work with the State agency to verify corrective action.
A-09-13-02001	California Withdrew Excessive Federal Medicaid Funds for Fiscal Year 2010	12/17/2015	We recommend that the State agency ensure that it reports the appropriate amounts on the CMS-64s.	Concur	2020	In Progress	CMS continues to work with the State agency to verify corrective action.
A-09-13-02001	California Withdrew Excessive Federal Medicaid Funds for Fiscal Year 2010	12/17/2015	We recommend that the State agency strengthen procedures to obtain funds from the appropriate Payment Management System accounts.	Concur	2020	In Progress	CMS continues to work with the State agency to verify corrective action.
A-09-14-01007	Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants	2/17/2016	We recommend that the Nevada marketplace develop a written policy that explains how to perform cost allocations and emphasizes the necessity to use updated, better data when available.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.

A-09-14-01007	Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants	2/17/2016	We recommend that the Nevada marketplace strengthen staff oversight to ensure (1) application of updated, better data to properly allocate costs and (2) allocation of costs for all allocable project components.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-09-14-01007	Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants	2/17/2016	We recommend that the Nevada marketplace refund to CMS $893,464, consisting of $26,685 that was misallocated to the establishment grants by not using updated, better data and $866,779 that was misallocated to the establishment grants for BOS components that also benefited Medicaid, or work with CMS to resolve the amounts misallocated to the establishment grants.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-09-14-01007	Nevada Misallocated Costs for Establishing a Health Insurance Marketplace to Its Establishment Grants	2/17/2016	We recommend that the Nevada marketplace work with CMS to ensure that costs claimed after our audit period are allocated correctly, using an updated cost allocation methodology.	TBD	2020	In Progress	CMS is working with OGC on this matter, and expects to submit an clearance document to the OIG by June 30, 2020 Opinion will be determined at the time clearance documentation is submitted.
A-09-14-02012	Washington State Claimed Federal Medicaid Reimburseme nt for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	9/15/2016	We recommend that the State agency work with CMS to determine what portion of the $10,842,919 Federal share claimed was unallowable for Federal Medicaid reimbursement and refund to the Federal Government the unallowable amount	Concur	2020	In Progress	The State agency has returned the funds but have not reported them on the CMS-64. CMS will close once the CMS-64 reflects the collection.

[A-09-14-02012]	Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	9/15/2016	We recommend that the State agency review all paid claims before our audit period for inpatient hospital services with dates of admission from January 1, 2010, through June 30, 2012, to determine whether payments should be adjusted for any claims that contained PPCs and: a POA code indicating that the condition was not present on admission, a POA code indicating that the documentation in the patient's medical record was insufficient to determine whether the condition was present on admission, or no POA code	Concur	2020	In Progress	The State agency has reviewed claims and returned the funds but have not reported them on the CMS-64. CMS will close once the CMS-64 reflects the collection.
[A-09-14-02012]	Washington State Claimed Federal Medicaid Reimbursement for Inpatient Hospital Services Related to Treating Provider-Preventable Conditions	9/15/2016	We recommend that the State agency refund to the Federal Government its share of any unallowable amounts for those paid claims reviewed.	Concur	2020	In Progress	The State agency has reviewed claims and returned the funds but have not reported them on the CMS-64. CMS will close once the CMS-64 reflects the collection.
[A-09-14-02030]	California Incorrectly Claimed Additional Medicaid Funding Authorized Under the Recovery Act When Reclaiming Overpayments Made to Bankrupt or Out-of-Business Providers	4/20/2017	We recommend that the State agency ensure that it uses the FMAPs in effect when the original overpayments were made and refunded when claiming Federal reimbursement for uncollectible overpayments.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency

A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs	1/7/2016	We recommend that the State agency strengthen the NDC edit (implemented on April 1, 2009) to ensure that NDCs are captured and valid for all claims for physician-administered drugs.	Concur	2020	In Progress	CMS will work with the drug rebates experts in central office on the DHCS drug methodology and the State's implementation SDN 14054. We will ensure those methodology and implemented procedure are in compliance with the federal drug rebate requirements.
A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs	1/7/2016	We recommend that the State agency work with CMS to determine the unallowable portion of the $27,349,486 (Federal share) for other claims for physician-administered drugs that were ineligible for Federal reimbursement and refund that amount.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs	1/7/2016	We recommend that the State agency refund to the Federal Government $4,392,568 (Federal share) for claims for single-source and top-20 multiple-source physician-administered drugs that were ineligible for Federal reimbursement.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing	1/7/2016	We recommend that the State agency determine and refund the unallowable portion of Federal reimbursement for physician-administered drugs that were not billed for rebates beginning July 1, 2008, for	Concur	2020	In Progress	CMS is working with the state to verify corrective action

	Manufacturers for Rebates for Some Physician-Administered Drugs		quarters not included within our audit period.				
A-09-14-02038	California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs	1/7/2016	We recommend that the State agency improve oversight of the processes for rebate billing and collection to ensure submission to manufacturers of drug utilization data for claims for physician-administered drugs.	Concur	2020	In Progress	CMS will work with the drug rebates experts in central office on the DHCS drug methodology and the State's implementation SDN 14054. We will ensure those methodology and implemented procedure are in compliance with the federal drug rebate requirements.
A-09-15-02014	California Improperly Claimed Enhanced Federal Reimbursement for Selected Claim Lines for Medicaid Family Planning Drugs and Supplies in Los Angeles and Orange Counties	3/23/2016	We recommend that the State agency strengthen internal controls to prevent duplicate payments for family planning drug and supply claims.	Concur	2020	In Progress	CMS is working with the State to understand 1) how the implemented EPC will prevent duplicate payment and deny those duplicated claims; and 2) What does state mean that they created EPC to offset duplicate claims.
A-09-15-02014	California Improperly Claimed Enhanced Federal Reimbursement for Selected Claim Lines for Medicaid Family Planning Drugs and Supplies in Los Angeles	3/23/2016	We recommend that the State agency review its paid claims for family planning drugs and supplies from the other counties in California for our audit period and all counties for subsequent years to identify any duplicate payments and refund to the Federal Government its share of any unallowable amounts claimed.	Concur	2020	In Progress	CMS is working with the State to understand 1) how the implemented EPC will prevent duplicate payment and deny those duplicated claims; and 2) What does state mean that they created EPC to offset duplicate claims.

	and Orange Counties						
A-09-15-02014	California Improperly Claimed Enhanced Federal Reimbursement for Selected Claim Lines for Medicaid Family Planning Drugs and Supplies in Los Angeles and Orange Counties	3/23/2016	We recommend that the State agency ensure that providers comply with State agency policies and procedures requiring them to verify the accuracy of submitted claims for family planning drugs and supplies.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-15-02027	California Created a Medicaid Program Vulnerability by Reporting Placeholders That Did Not Represent Actual Expenditures Supported by Documentation	8/8/2018	We recommend that the State agency develop and implement policies and procedures to ensure that supporting documentation for placeholders that it reports is (1) available at the time the CMS-64 is filed and (2) retained.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-15-02027	California Created a Medicaid Program Vulnerability by Reporting Placeholders That Did Not Represent Actual Expenditures	8/8/2018	We recommend that the State agency work with CMS to resolve the $1,154,016,418 of additional Medicaid placeholders reported on the CMS-64 for FY 2013 and any placeholders reported on the CMS-64 for prior and later FYs and determine whether adjustments should be made to the amounts reported.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency

	Supported by Documentation						
A-09-15-02027	California Created a Medicaid Program Vulnerability by Reporting Placeholders That Did Not Represent Actual Expenditures Supported by Documentation	8/8/2018	We recommend that the State agency report on the CMS-64 only actual expenditures that are supported by documentation.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-15-02035	California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations	12/8/2016	We recommend that the state agency work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs with NDCs were eligible for rebates and, if so, upon receipt of the rebates, refund the estimated $404,460 (Federal share).	Concur	2020	In Progress	CMS is working with the State and the OIG in reviewing supporting documentation
A-09-15-02035	California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations	12/8/2016	We recommend that the State agency work with CMS to determine the unallowable portion of the estimated $34,853,747 (Federal share) for other physician-administered drugs without NDCs that were eligible for rebates and, upon receipt of the rebates, refund that amount;	Concur	2020	In Progress	CMS is working with the State and the OIG in reviewing supporting documentation

A-09-15-02035	California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations	12/8/2016	We recommend that the State agency bill for and collect from manufacturers rebates for single-source and top-20 multiple-source physician-administered drugs dispensed to enrollees of MCOs and refund to the Federal Government the estimated $7,306,209 (Federal share).	Concur	2020	In Progress	CMS is working with the State and the OIG in reviewing supporting documentation
A-09-15-02035	California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations	12/8/2016	We recommend that the State agency work with its MCOs to ensure submission of drug utilization data for physician-administered drugs dispensed to enrollees.	Concur	2020	In Progress	CMS is working with the State agency to verify corrective action.
A-09-15-02035	California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations	12/8/2016	We recommend that the State agency implement a rebate and NDC reporting requirement in its MCO contracts to ensure that all MCOs submit drug utilization data for physician-administered drugs.	Concur	2020	In Progress	CMS is working with the State agency to verify corrective action.
A-09-15-02039	Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services	5/29/2018	We recommend that the State agency strengthen its policies and procedures to ensure that it performs retrospective reviews of billing data from all inpatient hospitals to identify PPCs.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency

	Related to Provider-Preventable Conditions						
A-09-15-02039	Nevada Did Not Comply With Federal and State Requirements Prohibiting Medicaid Payments for Inpatient Hospital Services Related to Provider-Preventable Conditions	5/29/2018	We recommend that the State agency review retrospective review reports for our audit period and after our audit period to determine whether payments should be reduced for any claims that contain PPCs and refund to the Federal Government its share of any unallowable amounts.	Concur	2020	In Progress	CMS is working with the state to determine the actual amount of refunds to the Federal Government
A-09-15-02040	California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimburseme nt for Specialty Mental Health Services	8/8/2018	We recommend that the State agency strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements by implementing policies and procedures to follow up on the implementation of each health plan's plan of correction in a timely manner.	Concur	2020	In Progress	The State agency is conducting focused reviews of MHPs. CMS is continuing to monitor corrective action.
A-09-15-02040	California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimburseme nt for Specialty Mental Health Services	8/8/2018	We recommend that the State agency strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements by assessing whether those oversight procedures are effective and, if they are not effective, identifying and implementing additional oversight procedures.	Concur	2020	In Progress	CMS has requested additional documentation from the State agency to verify corrective action.

A-09-15-02040	California Claimed Millions of Dollars in Unallowable Federal Medicaid Reimbursement for Specialty Mental Health Services	8/8/2018	We recommend that the State agency strengthen its oversight of the health plans to ensure that SMHS claims comply with Federal and State requirements by implementing oversight procedures, such as conducting more frequent and focused reviews of the health plans, providing additional training and technical assistance to the plans, and imposing fines, sanctions, or penalties on the plans	Concur	2020	In Progress	CMS has requested additional documentation from the State agency to verify corrective action.
A-09-16-01002	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs	9/25/2017	To improve its oversight of State marketplaces, we recommend that CMS set firm deadlines for marketplaces to fully develop system functionality for verifying applicants' eligibility and resolving inconsistencies, assess potential enforcement mechanisms that would ensure that marketplaces meet those deadlines, and, if such mechanisms are identified, seek legislative authority to establish them.	Non-Concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
A-09-16-01002	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs	9/25/2017	To improve its procedures for SMART reviews, we recommend that CMS continue to work with marketplaces to develop the reporting capability to ensure that all required data elements in the Quarterly Metrics Reports are submitted.	Concur	2022	In progress	SMIP continues to work with SBEs for submission of the Quarterly Metrics. CMS made changes to the Quarterly Metrics template in 10/2017 and implemented in SBEs 04/2018. SBEs have reported resource constraints in building full reporting functionality for the Quarterly Metrics. Per informal CMS guidance, SBEs have prioritized efforts to ensure all OE Weekly and Monthly data elements are submitted as required

[A-09-16-01002]()	CMS Did Not Provide Effective Oversight To Ensure That State Marketplaces Always Properly Determined Individuals' Eligibility for Qualified Health Plans and Insurance Affordability Programs	9/25/2017	To improve its procedures for SMART reviews, we recommend that CMS require marketplaces to submit additional data elements related to (1) average length of time to resolve inconsistencies, (2) number of unresolved inconsistencies, and (3) number of applicants for whom the marketplace received an FTR response code from the IRS and who were determined eligible for insurance affordability programs.	Concur	2022	In progress	CMS adjusted the Quarterly Metrics Report to include metrics related to inconsistency resolution, total numbers of unresolved inconsistencies, and FTR resolution. The revised Quarterly Metrics Report template with these additions was approved through the PRA 10/2017. SBEs continue to implement the revised Quarterly Metrics Report on a staggered basis due to build timelines. SBEs were required to submit metrics related to inconsistency and resolution since the PY 2018 Quarterly Metrics Report, and this will continue in PY 2019.
[A-09-16-02023]()	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency ensure that CalHEERS and SAWS have the system functionality to: deny or discontinue Medicaid for an ineligible beneficiary after a previous determination has already been made on the basis of the beneficiary's MAGI, properly process cases for beneficiaries who were formerly in the foster-care youth program, use SSA data to verify whether a beneficiary is entitled to or enrolled in Medicare, properly redetermine eligibility when a beneficiary is no longer a child, and retrieve and use information from the Department of Homeland Security to determine whether a beneficiary has met the 5-year-bar requirement to be eligible to receive full-scope Medicaid services.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.
[A-09-16-02023]()	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries	2/20/2018	We recommend that the State agency ensure that eligibility caseworkers properly input applicant information.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.

	Who Did Not Meet Federal and State Requirements						
A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency ensure that all eligibility requirements are properly verified.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.
A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency develop and implement written policies and procedures, as necessary, to ensure that all payments for nonemergency and non-pregnancy-related services are adjusted for beneficiaries who are subject to the 5-year bar.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.
A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries who did not meet or may not have met Federal and State eligibility requirements.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.

A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency ensure that eligibility determinations are made in accordance with Federal and State requirements for beneficiaries: who do not provide the required information, e.g., citizenship or lawful presence status, whose presumptive eligibility period has ended, and who may not have met the residency requirement.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.
A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements	2/20/2018	We recommend that the State agency develop and implement written policies and procedures to ensure that applicants who did not want or did not intend to apply for Medicaid are not determined eligible.	Concur	2020	In Progress	The State agency is working on providing CMS supporting documentation for corrective action.
A-09-16-02027	The California Department of Health Care Services should take appropriate action against dental providers with questionable billing.	9/12/2017	We recommend the State agency strengthen its internal controls to ensure that it bills for and collects from manufacturers rebates for all physician-administered and pharmacy drugs dispensed to MCO enrollees.	Concur	2020	In Progress	CMS is in the process of reviewing supporting documentation provided by the State agency.
A-09-16-02028	Washington State Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to $395,746 (Federal share) of the rebates collected.	Concur	2020	In Progress	CMS is working with the State agency to determine any return of funds.

A-09-16-02028	Washington State Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency work with CMS to determine the amount of any rebates due for the 17,140 claim lines that we set aside and refund the Federal share of rebates collected.	Concur	2020	In Progress	CMS continues to monitor the State agency's corrective action.
A-09-16-02028	Washington State Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency bill for and collect from manufacturers rebates for pharmacy drugs and refund to the Federal Government $14,237,150 (Federal share).	Concur	2020	In Progress	CMS is working with the State agency to determine any return of funds.
A-09-16-02028	Washington State Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency bill for and collect from manufacturers rebates for single-source and top-20 multiple-source physician-administered drugs and refund to the Federal Government $2,424,590 (Federal share).	Concur	2020	In Progress	CMS is working with the State agency to determine any return of funds.
A-09-16-02028	Washington State Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency determine which pharmacy and physician-administered drugs were not billed for rebates after our audit period, determine the rebates due, and, upon receipt of the rebates, refund the Federal share of the rebates collected.	Concur	2020	In Progress	CMS is working with the State agency to determine any return of funds.

A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency work with CMS to determine whether the other physician-administered drugs, associated with 122,436 claim lines, were eligible for rebates and, if so, determine the rebates due and upon receipt of the rebates refund the Federal share of the rebates collected.	Concur	2020	In Progress	CMS is working with the State agency to identify drug rebate claims and refund associated collections.
A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency bill for and collect from manufacturers rebates for pharmacy drugs and refund to the Federal Government $8,045,840 (Federal share).	Concur	2020	In Progress	CMS is monitoring the State agency's efforts to identify claims eligible for rebate and associated collections.
A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency bill for and collect from manufacturers rebates for single-source and top-20 multiple-source physician-administered drugs and refund to the Federal Government $1,632,332 (Federal share).	Concur	2020	In Progress	CMS is working with the State agency to identify drug rebate claims and refund associated collections.
A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency determine which physician-administered drugs were not billed for rebates after our audit period, determine the rebates due, and upon receipt of the rebates refund the Federal share of the rebates collected.	Concur	2020	In Progress	CMS is awaiting supporting documentation from the State agency to demonstrate the improved process for determining which physician-administered drugs were not billed for rebates after the audit period.

A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency improve oversight of the processes for rebate billing and collection to ensure that MCOs submit valid and complete drug utilization data for pharmacy and physician-administered drugs dispensed to MCO enrollees.	Concur	2020	In Progress	CMS is awaiting supporting documentation from the State agency to demonstrate improved process for rebate billing and collection.
A-09-16-02029	Hawaii Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	9/26/2017	We recommend that the State agency work with CMS to determine whether the non-top-20 multiple-source physician-administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to $57,783 (Federal share) of rebates collected.	Concur	2020	In Progress	CMS is working with the State agency to identify drug rebate claims and refund associated collections.
A-09-16-02031	Arizona Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	2/16/2018	We recommend that the State agency strengthen the NDC edit (implemented on October 1, 2012) to ensure that NDCs are captured and valid for all drug utilization data.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-16-02031	Arizona Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	2/16/2018	We recommend that the State agency work with CMS to determine whether the other physician-administered drugs were eligible for rebates and, if so, upon receipt of the rebates, refund up to an estimated $7,307,853 (Federal share) of rebates collected.	Concur	2020	In Progress	CMS is working with the State agency and the OIG to determine the refund amount.
A-09-16-02031	Arizona Did Not Bill Manufacturers for Some Rebates for Drugs	2/16/2018	We recommend that the State agency bill for and collect from manufacturers rebates for single-source and top-20 multiple-source physician-administered drugs and refund	Concur	2020	In Progress	CMS is working with the State agency and the OIG to determine the refund amount.

	Dispensed to Enrollees of Medicaid Managed-Care Organizations		to the Federal Government the estimated $18,326,775 (Federal share).				
A-09-16-02031	Arizona Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	2/16/2018	We recommend that the State agency ensure that all physician-administered drugs eligible for rebates are processed for rebates.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
A-09-16-02034	Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests	2/14/2018	We recommend that CMS direct the Medicare contractors to recover the $66,309,751 in identified improper payments.	Concur	2020	In progress	SMRC to generate more recent claims data and perform medical review.
A-09-16-02034	Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests	2/14/2018	We recommend that CMS strengthen its system edits to prevent improper payments for specimen validity tests and instruct the Medicare contractors to educate providers on properly billing for specimen validity and urine drug tests, which could result in savings of an estimated $12,146,760 over a 5-year period.	Concur	2020	In progress	CMS is continuing to examine the feasibility of implementing FPS2 edits with the goal of determining whether implementation of such edits is possible without increasing provider burden or reducing access to care for beneficiaries with these conditions. If such edits are possible, CMS will work with contractors to provide national education to providers on properly billing for urine drug tests.
A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than	2/14/2018	We recommend that CMS require the Medicare contractors to implement nation-wide prepayment edits to deny payments for emergency ambulance transports to destinations not covered by Medicare.	Concur	2020	In progress	CMS working on closure submission.

	Hospitals or Skilled Nursing Facilities						
A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	We recommend that CMS require the Medicare contractors to implement nation-wide prepayment edits to ensure that payments to providers for nonemergency ambulance transports comply with Federal requirements.	Concur	2020	In progress	CMS wotking on closure submission
A-12-12-00001	Personal Care Services: The OIG Portfolio	11/15/2012	CMS should promulgate regulations to improve CMS's and States' ability to monitor billing and care quality by requiring States to (1) either enroll all PCS attendants as providers or require all PCS attendants to register with their State Medicaid agencies and assign each attendant a unique identifier and (2) require that PCS claims include the specific date(s) when services were performed and the identity of the rendering PCS attendants.	Concur	2019	In progress	CMS anticipates an annual status update to OIG in December 2019. CMS continues to collaborate to determine the feasibility of requiring NPI identifiers for personal care attendants. CMS is working towards determining legal and policy next steps.
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	We recommended that Maryland complete a formal system security plan for the MMIS and supporting systems processing Medicaid data that details the system security requirements and the controls in place for meeting Federal requirements.	Concur	2020	In Progress	The State agency is developing a RFP for a vendor to perform a formal risk analysis and system Security Plan (SSP) for the MMIS and supporting systems. CMS continues to monitor the State's corrective action.
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and	8/9/2018	We recommended that Maryland complete a formal risk analysis for the MMIS and the supporting systems processing Medicaid data in	Concur	2020	In Progress	The State agency is developing a RFP for a vendor to perform a formal risk analysis and system Security Plan (SSP) for the MMIS and supporting systems. CMS continues to monitor the State's corrective action.

	Information Systems		accordance with Federal requirements.				
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should patch vulnerabilities using manufacturer-recommended timeframes for network devices and servers.	Concur	2020	In Progress	The State agency is deploying a patch management solution for workstations and servers. CMS continues to monitor the State's corrective action.
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should establish baseline configurations for its network devices and servers to protect servers from unauthorized modifications.	Concur	2020	In Progress	Per the State, baseline configurations for network devices are stored in SolarWinds. Baseline configurations for EDITPS servers exist and baseline configurations for Other Medicaid servers is being completed. CMS continues to monitor the State's corrective action
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should configure audit logs on servers and databases in accordance with manufacturer's recommended guidance.	Concur	2020	In Progress	CMS is in the process of confirming the State's corrective action. Per the state, the single MS SQL server identified has been configured to the other EDITPS MS SQL servers
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should employ automated mechanisms to perform audit log reviews, analyses, and reporting processes to investigate and respond to suspicious activities.	Concur	2020	In Progress	The State is evaluating the options for automated log management of servers and databases. CMS continues to monitor the State's corrective action
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should encrypt sensitive data transmission using NIST-approved encryption mechanisms throughout the network, websites, and servers.	Concur	2020	In Progress	The State has implemented the IP Sec tunnel as a solution to secure connectivity between MDH and ADC. CMS is awaiting approval from the OIG to close.
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data	8/9/2018	Maryland should implement policies and procedures to implement secure configuration standards across	Concur	2020	In Progress	The State is planning to deploy pilot applications to the MDTHINK platform. CMS continues to monitor corrective action.

	and Information Systems		its servers, websites and network devices.				
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	Maryland should establish adequate password policy settings, including policies to enforce adequate password or passphrase settings for its network and servers, for password aging, and for account inactivity limits.	Concur	2020	In Progress	The state has verified all Electronic Date Interchange Transaction Processing System (EDITPS) servers for adequate password policy settings and believes corrective action is complete. CMS is the process of verifying corrective action.
A-18-16-30520	Maryland Did Not Adequately Secure Its Medicaid Data and Information Systems	8/9/2018	We recommended that Maryland upgrade operating systems that are no longer supported to versions supported by manufacturers.	Concur	2020	In Progress	Per the State, data has been exported from the legacy software for import into LTSS. Corrective action is ongoing to determine next steps for import into LTSS. CMS continues to monitor corrective action.
OEI-01-08-00590	Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events	10/31/2011	Require that all Immediate Jeopardy complaint surveys evaluate compliance with the Conditions of Participation on quality assurance and performance improvement	Concur	2019	Awaiting Disposition	Per October 23rd OIG Response Memo- In its April 2019 update, CMS also stated that it plans to take no further action with respect to this recommendation. We acknowledge that CMS plans no further action on our recommendation and appreciate the steps that CMS has taken. Although those steps elevate the prominence of the QAPI CoP, they do not fully implement our recommendation. Therefore, we consider this recommendation closed and will no longer track its status though annual updates from CMS.
OEI-01-10-00460	Limited Oversight of Home Health Agency OASIS Data	2/27/2012	Develop clear guidelines that delineate expectations for States regarding timely and accurate OASIS data	Non-Concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any action
OEI-01-10-00460	Limited Oversight of Home Health Agency OASIS Data	2/27/2012	Establish and implement enforcement actions for HHAs that submit OASIS data after the 30-day deadline	Non-Concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any action

OEI-01-11-00550	The ESRD Beneficiary Grievance Process	12/20/2013	The OIG recommends that CMS work with AHRQ to add a question to CAHPS to assess beneficiaries' fear of reprisal. Once facilities transition to the CARPS survey, it is unlikely that they will also conduct their own surveys. As a result, far fewer facilities will capture data from beneficiaries regarding fear of reprisal. CMS could work with AHRQ on adding a small number of questions designed to capture this information. CMS would then be able to better measure the extent to which ESRD beneficiaries throughout the country fear reprisal for voicing grievances about their care.	Non-concur	2020	In progress	CMS engaged patients on April 3, 2019 to receive input on activities to be included in future scopes of work. No patient identified retaliation as an area of concern, but they did address the need to incorporate patients into the culture of the facility. Patients indicated strategies to ensure patients feel they are heard, respected, and included in their care should be promoted. CMS will continue in this and future scopes of work to educate and encourage facilities to include patients in internal quality improvement meetings, develop support groups, and encourage patient participation in care planning meetings. CMS developed brief educational documents in a workgroup with patients and dialysis staff. The two documents one for patients and one for dialysis facility staff can be incorporated into the workflow of the dialysis facility to improve the facility culture. These documents are in draft form and are included with this update. These documents will also be posted to the ESRD National Coordinating Center's website. • Actively pursuing patient input into activities to be undertaken in future scopes of work. (Complete) • Create patient workgroup to develop education for patients and staff regarding retaliation. (Complete) • Post education on the National Coordinating Center website. As patients view the materials they will be requested to answer if they have experienced retaliation by dialysis facility staff. (In progress and will be completed by the end of the year. Response from survey of this request will be submitted January 2020).
OEI-01-11-00500	Local Coverage Determinations Create Inconsistency in Medicare Coverage	1/7/2014	CMS should establish a plan to evaluate new LCDs for national coverage consistent with MMA requirements.	Concur	2016	Awaiting Disposition	CMS feels actions in response to this recommendation are complete and plans to take no further action. OIG has responded that they will still consider the recommendation unimplemented but no longer track it for followup.
OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology	12/9/2013	Audit logs be operational whenever EHR technology is available for updates or viewing.	Concur	2016	Awaiting Disposition	CMS actions are complete. Per ASU Response Memo November 2016 - OIG is treating CMS's response as its notification of final action but continue to consider the recommendation unimplemented
OEI-01-11-00570	Not All Recommended Fraud Safeguards Have Been Implemented in Hospital	12/9/2013	ONC and CMS strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs.	Concur	2019	Awaiting Disposition	CMS feels actions in response to this recommendation are complete and plans to take no further action. OIG stated, "As CMS does not plan to take any action, we will treat its response as its Notification of Final Action. OIG will continue to consider the recommendation unimplemented."

	EHR Technology						
OEI-01-12-00150	The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness	10/2/2013	We recommend that CMS use the Medicare Appeals System (MAS) to monitor contractor performance.	Concur	2019	In progress	CMS continues our efforts to seek funding for onboarding the remaining MACs (Part B and DME) onto MAS. Recently, CMS received FY18 funding to partially onboard 1 Part B and 1 DME MAC to MAS for data collection, reporting, and case file transfer only. With this approach, MACs would continue to be able to innovate and experience in-house developed operational efficiencies using their internal workflow and correspondence systems, while also allowing CMS to explore enhanced monitoring of MAC Part B and DME workload. This solution will control MAC operational costs by incrementally allowing for seamless integration into their current workflow and not negatively impact current MAC operating budgets. Web services would assist MACs with updating MAS with data from their internal systems. To account for the complexity of incorporating this new type of workload in MAS, this pilot would allow for all MAC jurisdictions to assist in the development of requirements. Piloting expansion of MAS to include MAC data for Part B and DME Level 1 FFS claims appeals will show positive movement towards achieving this CMS priority.
OEI-01-14-00200	CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services	9/29/2015	CMS should establish a more reliable control for identifying active treatment	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
OEI-02-08-00050	Concerns With Rebates in the Medicare Part D Program	3/3/2011	Ensure that sponsors appropriately report the fees that pharmacy benefit managers collect from manufacturers	Concur	2018	In progress	CMS will continue collecting from Part D sponsors all amounts from drug manufacturers as direct and indirect remuneration.
OEI-02-08-00050	Concerns With Rebates in the Medicare Part D Program	3/3/2011	Require sponsors to use methods CMS deems reasonable to allocate rebates across plans	Concur	2018	In progress	CMS in progress after initially non-concurring with the recommendation.

OEI-02-08-00170	Oversight of Quality of Care in Medicaid Home and Community Based Services Waiver Programs	6/21/2012	CMS Should Require At Least One Onsite Visit Before a Waiver Program is Renewed and Develop Detailed Protocols for Such Visits	Concur	NA	Awaiting Disposition	Per OIG, 01/17/18 - status is unimplemented, but updates are no longer required and CMS considers the recommendation closed. OIG continues to hold this recommendation on their outstanding recommendation list. This should be closed/unimplemented CMS is taking no further actions and updates are not required by the OIG.
OEI-02-08-00460	Medicare Part D Reconciliation Payments for 2006 and 2007	9/1/2009	Hold sponsors more accountable for inaccuracies in the bids	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-02-09-00200	Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009	11/9/2012	CMS should change the current method for determining how much therapy is needed to ensure appropriate payments.	Concur	2020	Awaiting Disposition	Additional supporting documents for closure submitted Oct 2019.
OEI-02-09-00200	Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009	11/9/2012	CMS should monitor compliance with the new therapy assessments.	Concur	2019	Awaiting Disposition	OIG closed recommendation implemented November 2019
OEI-02-09-00605	Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills	9/26/2012	CMS should follow up on sponsors and pharmacies with high numbers of refills.	Concur	2020	In progress	CMS-0055-P was published in the Federal Registry on January 31, 2019. (See https://www.govinfo.gov/content/pkg/FR-2019-01-31/pdf/2019-00554.pdf). Comments were due April 1, 2019 and the final rule is scheduled to be published 12/20/2019. If published on time the effective date would be 2/20/2020 (60 days after publication) and a compliance date of 8/20/2020 (180 days after the effective date). As the final rule is still in clearance, these target dates are subject to change.

OEI-02-09-00605	Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills	9/26/2012	CMS should exclude Schedule II refills when calculating payments to sponsors.	Non-concur	NA	Awaiting Disposition	The OIG recommended that we exclude CII refills when calculating payments to sponsor and put it place system edits to prevent CII refills. We agreed to look into putting system edits in place. However, after careful consideration, we believe that, once implemented, the NCPDP system changes will adequately capture partial fills of C II drugs. We non-concurred with excluding the CII refills when calculating payments to sponsors because we believed that the OIG identified legal partial fills of CII drugs to patients in LTC facilities, as opposed to illegal refills of CII drugs. The work that the NCPDP is doing to account for legally permissible partial fills of CII drugs helps to support our belief. CMS considers this matter closed.
OEI-02-10-00040	CMS Response to Breaches and Identity Theft	10/9/2012	CMS should develop a method for ensuring that beneficiaries who are victims of medical identity theft retain access to needed services.	Non-Concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	Revise the requirements in the local coverage determination.	Concur	2017	Awaiting Disposition	Per May 2019 Response Memo- We will keep this recommendation open pending future research that may help CMS clarify the definitions of beneficiaries' potential functional levels in the local coverage determination, which would help to better ensure that prostheses are matched to beneficiaries' needs. We will consider this recommendation implemented when CMS provides more clarity in this area in the local coverage determination. However, we will no longer request Annual Status Updates. When CMS has documentation please, send it to us so we can consider the recommendation implemented.
OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	Implement requirements for a face-to-face encounter with the referring physician.	Concur	2021	In progress	CMS continues to explore requiring prior authorization of lower-limb prostheses.
OEI-02-10-00170	Questionable Billing by Suppliers of Lower Limb Prostheses	8/17/2011	Enhance screening for currently enrolled suppliers of lower limb prostheses.	Non-concur	NA	Awaiting Disposition	CMS non-concurs with recommendation and has no actions forecasted.
OEI-02-10-00340	Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals	11/14/2012	OMHA and CMS should standardize case files and make them electronic	Concur	2017	Awaiting Disposition	CMS implemented a standard operating procedure (SOP) for receipt and delegation of policy recommendations, and included a process for tracking the progress of recommendations from receipt to implementation. Per OIG's instruction, the SOP was submitted to close out this item on 10/28/2016. OIG requested a tracking log, and this was submitted 8/29/19

Report	Title	Date	Recommendation	Response	Year	Status	Comments
OEI-02-10-00340	Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals	11/14/2012	OMHA and CMS should improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary	Concur	2018	Awaiting Disposition	The electronic interface with OMHA will not be fully functioning until ECAPE is implemented. OMHA apprises CMS of the status of the ECAPE project at monthly Medicare Appeals System (MAS) Operation Board meetings. CMS and OMHA have made progress in implementing electronic case file functionality. CMS and the Qualified Independent Contractors (QICs) use the electronic case file environment of the Medicare Appeals System (MAS). CMS onboarded the remainder of Part A MACs to MAS in April 2017. As funding permits, CMS will continue to work with the system owner to determine the optimal approach to achieving consistent data at Level 1 of the appeals process, and the possibility of onboarding Part B and DME MACs to MAS in the future. CMS defers to OMHA for the progress of the ECAPE implementation.
OEI-02-10-00340	Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals	11/14/2012	OMHA and CMS should identify and clarify Medicare policies that are unclear and interpreted differently	Concur	2016	Awaiting Disposition	CMS is discussing resolution of this recommendation internally.
OEI-02-10-00491	Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care	3/20/2016	Follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care	Concur	2019	Awaiting Disposition	CMS sent OIG the results of the MAC HOSPICE GIP overpayment report and is awaiting their response.
OEI-02-10-00492	Hospices Should Improve Their Election Statements and Certifications of Terminal Illness	9/15/2016	CMS should provide guidance to hospices regarding the effects on beneficiaries when they revoke their election and when they are discharged from hospice care.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
OEI-02-11-00320	State Standards for Access to Care in Medicaid Managed Care	9/25/2014	CMS should strengthen its oversight of State standards and ensure that States develop standards for key providers.	Concur	2021	In progress	met with OIG 9/18/19. revised ASU to include the highlights of the ongoing development of continuous improvement actions discussed in the meeting is in development.

OEI-02-11-00320	State Standards for Access to Care in Medicaid Managed Care	9/25/2014	CMS should strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards.	Concur	2021	In progress	CMS met with OIG 9/18/19 and revised ASU to include the highlights of the ongoing development of continuous improvement actions discussed in the meeting is in development.
OEI-02-11-00320	State Standards for Access to Care in Medicaid Managed Care	9/25/2014	CMS should improve States' efforts to identify and address violations of access standards.	Concur	2021	In progress	CMS met with OIG 9/18/19 and revised ASU to include the highlights of the ongoing development of continuous improvement actions discussed in the meeting is in development.
OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	CMS should change the method of paying for therapy	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	CMS should adjust Medicare payments to eliminate the effect of case mix-creep	Concur	2020	In progress	CMS issued an Advanced Notice of Proposed Rulemaking on April 27, 2017 to solicit public comments on options it may consider for revising certain aspects of the existing skilled nursing facility (SNF) prospective payment system methodology. In particular, CMS sought comments on the possibility of replacing the current SNF payment system with a new case-mix model. CMS signaled that it intends to propose case mix refinements in the fiscal year (FY) 2019 SNF prospective payment system proposed rule.
OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	CMS should evaluate the extent to which Medicare payment rates for therapy should be reduced.	Concur	2020	In progress	CMS reports that it continues to explore and consider various approaches to adjust SNF payments. These approaches include potentially using its statutory authority to adjust payment rates if CMS determines that overall payments to SNFs have changed across the SNF payment system that are unrelated to beneficiaries' characteristics. CMS also believes that the possible, new case-mix model would greatly enhance its ability to identify and eliminate case mix creep from the SNF prospective payment system.
OEI-02-13-00610	The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated	9/29/2015	CMS should strengthen oversight of SNF billing	Concur	2019	Awaiting Disposition	This recommendation was closed - implemented on 10/18/2019.

OEI-02-13-00611	Skilled Nursing Facility Billing for Changes in Therapy: Improvements are Needed	6/30/2015	Strengthen the oversight of SNF billing for changes in therapy	Concur	2020	In progress	As of October 1, 2019, CMS is implementing the Patient Driven Payment Model in place of the RUG-IV payment structure changing the manner in which it pays for therapy services and eliminating the assessments at issue in the OIG's report. As such, we believe that this fully addresses the concerns raised by the OIG with these assessments and with payment for therapy services under the SNF PPS.
OEI-02-13-00611	Skilled Nursing Facility Billing for Changes in Therapy: Improvements are Needed	6/30/2015	Reduce the financial incentive for SNFs to use assessments differently when decreasing therapy than when increasing it	Concur	2020	Awaiting Disposition	CMS sent OIG documentation to close the recommendation and is waiting for their response.
OEI-02-13-00670	Access to Care: Provider Availability in Medicaid Managed Care	11/8/2014	CMS should work with States to assess the number of providers offering appointments and improve the accuracy of plan information.	Concur	2020	In progress	CMS met with OIG 9/18/19 and revised ASU to include the highlights of the ongoing development of continuous improvement actions discussed in the meeting is in development.
OEI-02-13-00670	Access to Care: Provider Availability in Medicaid Managed Care	11/8/2014	CMS should work with States to ensure that plans are complying with existing State standards and assess whether additional standards are needed.	Concur	2020	In progress	CMS met with OIG 9/18/19. Revised ASU to include the highlights of actions that will meet closure consideration requirements as discussed in the meeting.
OEI-02-13-00670	Access to Care: Provider Availability in Medicaid Managed Care	11/8/2014	CMS should work with States to ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees.	Concur	2020	In progress	CMS met with OIG 9/18/19. Revised ASU to include the highlights of actions that will meet closure consideration requirements as discussed in the meeting.
OEI-02-14-00480	Questionable Billing for Medicaid Pediatric Dental Services in Californ	5/15/2015	The Califonia Department of Health Care Services should take appropriate action against dental providers with questionable billing.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency
OEI-02-14-00480	Questionable Billing for Medicaid Pediatric Dental Services in California	5/15/2015	The California Department of Health Care Services should review its payment processes for orthodontic services.	Concur	2020	In Progress	CMS is reviewing supporting documentation provided by the State agency

OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	Work with States to analyze the effects of Medicaid payments on access to dental providers	Concur	2020	In progress	CMS will be conducting an analysis to understand the impact of Medicaid payment on access to dental providers.
OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	Ensure that States pay for services in accordance with their periodicity schedules	Concur	2020	In progress	CMS contractor analysis and evaluation in progress.
OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	Develop benchmarks for dental services and require States to create mandatory action plans to meet them	Non-concur	NA	Awaiting Disposition	CMS considers applicable actions complete. OIG will treat CMS's response as its notifications of final action, and updates are no longer required. However, OIG will continue to consider the following recommendations open-unimplemented. 11/16/16 - This should be closed/unimplemented CMS is taking no further actions and updates are not required by the OIG.
OEI-02-14-00490	Most Children With Medicaid in Four States Are Not Receiving Required Dental Services	1/20/2016	Work with States to track children's utilization of required dental services	Non-concur	NA	Awaiting Disposition	CMS considers applicable actions complete. OIG will treat CMS's response as its notifications of final action, and updates are no longer required. However, OIG will continue to consider the following recommendations open-unimplemented. 11/16/16 - This should be closed/unimplemented CMS is taking no further actions and updates are not required by the OIG.
OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	Conduct routine analysis of hospital billing and target for review the hospitals with high or increasing numbers of short inpatient stays that are potentially inappropriate under the 2-midnight policy	Concur	2020	In progress	CMS concurs with the recommendation. CMS will instruct the QIOs to conduct routine analysis of hospital billing for inpatient stays and target for review hospitals with high or increasing numbers of short inpatient stays.

OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	Analyze the potential impacts of counting time spent as an outpatient toward the 3-night requirement for SNF services so that beneficiaries receiving similar hospital care have similar access to these services	Concur	2020	In progress	CMS concurs with the recommendation. QIOs are currently conducting initial patient status reviews of short stays in acute care inpatient hospitals, long-term care hospitals, and inpatient psychiatric facilities to determine the appropriateness of Part A payment for short stay hospital claims.
OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	Explore ways of protecting beneficiaries in outpatient stays from paying more than they would have paid as inpatients	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-02-15-00020	Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy	12/19/2016	Identify and target for review the short inpatient stays that are potentially inappropriate under the 2-midnight policy	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to ensure that MCOs provide complete, accurate, and timely encounter data.	Concur	2020	In progress	The CMS' Center for Program Integrity (CPI) is working on a series of educational tool kits to help states identify potential managed care fraud. These will include information about managed care encounter data. CMS has also developed several sub-committees of technical advisory groups that meet to share best practices and emerging topics related to managed care fraud.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to increase MCO reporting of corrective actions taken against providers suspected of fraud or abuse to the State.	Concur	2020	In progress	CMS will work with states to discuss increasing the scope of reporting that results in actionable information, in line with CMS's authority in the final rule.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to identify and share best practices about payment retention policies and incentives to increase recoveries.	Concur	2020	In progress	CMS concurs with this recommendation and will work with states to clarify the information managed care organizations are required to report regarding providers who are terminated or regarding providers that have had a change in circumstance that may affect the provider's ability to participate in the managed care program, in line with CMS's authority in the final rule.

OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to improve MCO identification and referral of cases of suspected fraud or abuse.	Concur	2020	In progress	CMS will work with states to share best practices about payment retention policies and incentives to obtain recoveries.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to improve coordination between MCOs and other State program integrity entities.	Concur	2020	In progress	CMS will work with states to improve coordination between managed care organizations and other state program integrity entities through regularly scheduled outreach and training courses.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to standardize reporting of referrals across all MCOs in the State.	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS believes that, while states should ensure that there are effective reporting mechanisms in place, they have the flexibility to decide whether standardization would be beneficial for their managed care environment.
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should monitor encounter data and impose penalties on States for submitting inaccurate or incomplete encounter data.	Concur	2020	In progress	Guidance development is in progress for State data quality for encounter data
OEI-02-15-00260	Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse	7/11/2018	CMS should work with States to clarify the information MCOs are required to report regarding providers that are terminated or otherwise leave the MCO network.	Concur	2020	In progress	Recommendation implementation in progress.
OEI-02-16-00440	Questionable Billing for Compounded Topical Drugs	8/7/2018	CMS should conduct training for Part D sponsors on fraud schemes and safety concerns related to compounded topical drugs.	Concur	2020	In progress	CMS's contractor-the MEDIC - analyzed Part D PDE data related to compounded (or topical) prescription drugs and shared the results of that study with Part D Plan Sponsors through PLATO in September 2016. The refinement of this project, was implemented in PLATO on February 9th, 2018.

	in Medicare Part D						
OEI-02-16-00440	Questionable Billing for Compounded Topical Drugs in Medicare Part D	8/7/2018	CMS should follow up on pharmacies with questionable Part D billing and the prescribers associated with these pharmacies.	Concur	2020	In progress	CMS conducted a Fraud, Waste and Abuse (FWA) training session in July 2018. CMS additionally issued an education memo in March 2018 to all Medicare Advantage and Part D Plan Sponsors on questionable prescribing and dispensing of lidocaine creams. CMS issued an educational memo in March 2018 to all Medicare Advantage and Sponsors on questionable prescribing and dispensing of lidocaine creams. During the July 11th session, a presentation was made d schemes that may involve topical and compounded prescription drugs.
OEI-02-16-00440	Questionable Billing for Compounded Topical Drugs in Medicare Part D	8/7/2018	CMS should conduct additional analysis on compounded topical drugs.	Concur	2020	In progress	CMS has accepted the referral from the OIG and reviewed the data. CMS will plan future action within the scope of our existing authorities. Next steps may include administrative actions, referral for investigation by the program integrity contractor, or referral to law enforcement.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should increase oversight of general inpatient care claims and focus particularly on general inpatient care provided in SNFs, given the higher rate at which these stays were inappropriate	Non-concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any action

OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should implement a comprehensive prepayment review strategy to address lengthy general inpatient care stays so that beneficiaries do not have to endure unnecessarily long periods of time in which their pain and symptoms are not controlled	Concur	2020	In progress	CMS has completed its review of surveys as previously stated and is finalizing plans to present the information as an educational webinar to surveyors. The review identified that plans of care were not individualized (56%); plans of care that were not consistently followed (70%), and Interdisciplinary Group (IDG) reviews of the plans of care were not documented every 15 days. Additionally 42% of the surveys indicated care was not coordinated in accordance with the plan of care. CMS believes a critical role responsible for the development, coordination, and follow through of the plan of care resides with the RN Coordinator of the hospice team. Based on these findings, CMS had developed its educational outreach to hospice surveyors to clarify these expectations. This educational activity will emphasize the need to interview the correct hospice staff (e.g. RN coordinator), how they investigate cares of plan that are not followed, and appropriate follow up documentation based on observation/record reviews. CMS previously indicated that it would provide each state a review of the hospice surveys included in this analysis. Given the consistency of findings in this area across states, we believe it would be more efficient to focus our efforts on the webinar development rather than disseminating mostly similar findings to each state. In developing the presentation, we intend to include additional content in the webinar to address the differentiation between standard, condition, and immediate jeopardy findings while discussing issues related to abuse and neglect in hospice. The webinar will include specific timeframes for facilitated discussion to engage surveyors on issues and challenges they perceive in surveying hospice providers. We anticipate this training to be conducted in August and will post a copy of it on the surveyor training website for those who cannot attend the live webinar. The next update will be on September 1, 2019. CMS will provide OIG the final presentation when completed, the announcement of the training, and a summary of the feedback following the event. This updated plan and extension is being requested due to the complexity of the issue being addressed, time needed to synchronize this response with other internal hospice initiatives, and competing workload requirements surrounding other OIG & GAO studies on the hospice program.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program	7/30/2018	CMS should adjust payments based on these analyses, if appropriate, to ensure that the payment system is aligned with beneficiary needs and quality of care	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

	Integrity: An OIG Portfolio						
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance.	Concur	2019	In progress	Link to the MAP Meeting December 10, 2018 Agenda showing Transition from Hospice Care claims-based measure was presented: Link to the FY 2020 OA Briefing showing Transition from Hospice Care claims-based measure to be proposed: https://share.cms.gov/center/CCSQ/QMHAG/DCPAC/Rules/FY-CY%202020%20Rules/Hospice%20QRP%20FY%202020%20Proposed%20Rule%20Briefing%20Overview%20for%20OA-DepSec%2012-7-2018.docx
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should develop other claims-based information and include it on Hospice Compare	Non-concur	NA	Awaiting Disposition	CMS Non-Concurs and will not take any action
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should analyze claims data to identify hospices that engage in practices or have characteristics that raise concerns.	Concur	2020	In progress	CMS considers actions complete. Hospice information is available on Medicare.gov as well as in numerous products including Medicare Hospice Benefits, Medicare and Hospice Benefits: Getting Started, Your Medicare Benefits, and the Medicare & You handbook. Individuals can order these products through our product ordering website, downloading on Medicare.gov, or calling 1-800-MEDICARE.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should work with its partners, such as hospitals and caregiver groups, to make available consumer-friendly information explaining the hospice benefit to beneficiaries and their families and caregivers.	Concur	2020	Awaiting Disposition	Hospice information is available on Medicare.gov as well as in the products Medicare Hospice Benefits, Medicare and Hospice Benefits: Getting Started, Your Medicare Benefits, and the Medicare & You handbook. CMS states that individuals can order these products, download them from Medicare.gov, or call 1-8OO-MEDICARE. CMS request OIG close recommendation.

OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should develop and execute a strategy to work directly with hospices to ensure that they are providing drugs covered under the hospice benefit as necessary and that the cost of drugs covered under the benefit are not inappropriately shifted to Part D	Concur	2020	In progress	CMS tasked its Supplemental Medical Review Contractor (SMRC) to complete data analysis on hospice claims to recommend a review methodology and identify a sample of providers. CMS developed a methodology and identified 143 billing providers with 1,973 claims in its final sample.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should modify the payments for hospice care in nursing facilities	Concur	2020	In progress	CMS will work to identify and take appropriate actions to follow up with hospices that have raised concern. After the SMRC reviews are complete CMS will analyze the results and determine appropriate next steps which could include targeted probe and educate reviews, referral to the Recovery Audit Contractors or referral to law enforcement as applicable.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should assess the current payment system to determine what changes may be needed to tie payments to beneficiaries' care needs and quality of care to ensure that services rendered adequately serve beneficiaries' needs	Concur	2020	In progress	CMS will work to increase oversight of general inpatient care through postpayment review.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should include on Hospice Compare deficiency data from surveys, including information about complaints filed and resulting deficiencies	Concur	2020	In progress	CMS' contractors currently conduct prepayment reviews of lengthy GIP stays in hospices that have been found to have high amounts of these stays and recoup any overpayments found as a result of these reviews. CMS notes that CMS medical review, including prepayment review, determines whether these stays were reasonable and necessary and met payment criteria.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should analyze claims data to inform the survey process.	Non-concur	NA	Awaiting Disposition	CMS does not concur with OIG's recommendation. CMS has oversight authority over Medicare Part D plan sponsors. CMS has directed certain plan sponsors to conduct audits for payments made for beneficiaries who are enrolled in hospice care to ensure that payments are made appropriately. CMS will continue its efforts to work with plan sponsors to address this issue.

OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should analyze deficiency data to inform the survey process.	Concur	2020	In progress	CMS will provide OIG the final presentation when completed, the announcement of the training, and a summary of the feedback following the event. This updated plan and extension is being requested due to the complexity of the issue being addressed, time needed to synchronize this response with other internal hospice initiatives, and competing workload requirements surrounding other OIG & GAO studies on the hospice program.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should take appropriate actions to follow up with hospices that engage in practices or have characteristics that raise concerns	Concur	2020	In progress	After the SMRC reviews are complete CMS will analyze the results and determine appropriate next steps which could include targeted probe and educate reviews, referral to the Recovery Audit Contractors or referral to law enforcement as applicable.
OEI-02-16-00570	Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio	7/30/2018	CMS should ensure that a physician is involved in the decisions to start and continue general inpatient care	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
OEI-03-02-00771	Use of Modifier 59 to Bypass Medicare's National Coding Initiative Edits	11/1/2005	CMS should ensure that the carriers' claims processing systems only pay claims with modifier 59 when the modifier is billed with the correct code.	Concur	2018	Awaiting Disposition	CMS believes the spirit of this recommendation to have been met and has not performed any further actions.
OEI-03-07-00380	Medicare Drug Plan Sponsor's Identification of Potential Fraud and Abuse	10/1/2008	Use this required information to help determine the effectiveness of sponsors' fraud and abuse programs.	Concur	2021	In progress	CMS included provisions in CY21 C/D rule
OEI-03-07-00380	Medicare Drug Plan Sponsor's Identification of Potential	10/1/2008	Determine whether the Part D sponsors that identified fraud and abuse initiated inquiries and corrective actions as required by CMS and made referrals for further	Concur	2021	In progress	CMS included provisions in CY21 C/D rule

	Fraud and Abuse		investigation as recommended by CMS.				
OEI-03-08-00030	Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors	5/1/2010	Require that PSCs, ZPICs, and claims processors have controls in their tracking systems to ensure that all overpayment referrals and data related to their collection status can be found.	Concur	2019	In progress	The PSCs/ZPICs send a letter to the Provider/Supplier informing them of an overpayment and indicate that the Affiliated Contractor (AC) MAC will be sending a demand letter in the near future. In the past, it was not a requirement for the AC/MAC to report back to the PSCs/ZPICs on any collections of the overpayment requests and they are not copied on the demand letters.
OEI-03-08-00480	Average Sales Prices: Manufacturer Reporting and CMS Oversight	2/12/2010	Develop an automated system for the collection of ASP data.	Concur	2021	In progress	CMS in progress
OEI-03-09-00410	States' Collection of Medicaid Rebates for Physician-Administered Drugs	5/6/2011	Take action against States that do not meet the DRA's requirement to collect rebates on physician-administered drugs.	Concur	2020	In Progress	CMS submitted an updated response to OIG.
OEI-03-09-00410	States' Collection of Medicaid Rebates for Physician-Administered Drugs	5/6/2011	Ensure that all State agencies are accurately identifying and collecting physician-administered drug rebates owed by manufacturers.	Concur	2020	In Progress	CMS submitted an updated response to OIG.
OEI-03-09-00510	Medicare Payments for Newly Available Generic Drugs	1/10/2011	CMS work with Congress to require manufacturers of first generics to submit monthly ASP data during the period of initial generic availability.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-03-10-00310	Medicare Advantage Organizations' Identification of Potential Fraud and Abuse	2/24/2012	Review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation.

OEI-03-10-00310	Medicare Advantage Organizations' Identification of Potential Fraud and Abuse	2/24/2012	Ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents	Concur	2021	In progress	CMS currently has a variety of training tools and works with plans through a series of webinars and in-person meetings to address how to identify, investigate and refer suspect FWA.
OEI-03-10-00500	Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors	12/1/2011	Require all benefit integrity contractors to report monetary impact, when calculable, in a consistent format	Non-concur	NA	Awaiting Disposition	The CMS does not concur with this recommendation. In some cases, CMS may be able to determine the monetary impact; however, requiring all benefit integrity contractors to report the monetary impact for each vulnerability and use it in a consistent methodology would prove challenging.
OEI-03-11-00310	MEDIC Benefit Integrity Activities in Medicare Parts C and D	1/9/2013	CMS should explore methods to develop and implement a mechanism to recover payments from Part C and Part D plan sponsors when law enforcement agencies do not accept cases involving inappropriate services for further action.	Concur	2020	In progress	CMS is working on a TDL which when completed should close the recommendation.
OEI-03-11-00350	Surety Bonds Remain an Underutilized Tool To Protect Medicare From Supplier Overpayments	3/21/2013	CMS should consider using the legislative authority given by the Affordable Care Act to require increased surety bonds based on suppliers' billing volume.	Concur	2020	In progress	CMS is currently assessing approaches to implementing a surety bond requirement while avoiding undue provider burden. At present, there is no timeline for preliminary CPI or CMS decisions on whether or how to proceed on this issue.
OEI-03-11-00410	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2010	11/10/2011	Consider seeking a legislative change to directly require all manufacturers of Part B-covered drugs to submit both ASPs and AMPs	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-03-11-00600	Medicare Supplier Acquisition Costs for L0631 Back Orthoses	12/18/2012	CMS should lower the fee schedule amount for the L0631 back orthosis.	Concur	2020	In progress	CMS agrees that Medicare should establish an appropriate price for L0631 back orthoses. CMS will examine this issue closely as it considers next steps in the area of DME payment.
OEI-03-11-00670	Medicare's Currently Not Collectible Overpayments	7/1/2013	CMS should ensure that the HIGLAS variable for provider type is populated for all overpayments.	Non-concur	NA	Awaiting Disposition	OIG will no longer require annual updates for this recommendation but will continue to consider it unimplemented. CMS considered closed 2017

OEI-03-11-00670	Medicare's Currently Not Collectible Overpayments	7/1/2013	CMS should ensure that demand letters are mailed to the contacts and addresses identified by the provider.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation, position remains unchanged.
OEI-03-11-00720	CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited	3/3/2014	CMS should determine whether outlier data values submitted by MA contracts reflect inaccurate reporting or atypical performance.	Non-concur	NA	Awaiting Disposition	Per OIG July 2019 Response Memo: Because CMS does not plan to take any new actions to address these recommendations, we will treat CMS's Revised Management Decision as its Notification of Final Action.
OEI-03-11-00720	CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited	3/3/2014	CMS should use appropriate Part C data as part of its reviews of MA contracts' performance.	Non-concur	NA	Awaiting Disposition	Per OIG July 2019 Response Memo: Because CMS does not plan to take any new actions to address these recommendations, we will treat CMS's Revised Management Decision as its Notification of Final Action.
OEI-03-12-00070	Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments	9/27/2012	CMS should implement the HHA surety bond requirement.	Concur	2020	In progress	The CMS concurs that implementing a surety bond requirement for Home Health Agencies (HHAs) may help reduce potential program vulnerabilities. CMS is currently evaluating its options in implementing this requirement. The surety bond rule would be a significant rule and thus subject to the Executive Order “Reducing Regulation and Controlling Regulatory Costs” issued by the President on January 30, 2017. Any further actions regarding a surety bond rule would be undertaken in that context.
OEI-03-12-00550	Update: Medicare Payments for End Stage Renal Disease Drugs	3/24/2014	CMS should distinguish payments in the ESRD base rate between independent and hospital-based dialysis facilities.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-03-12-00670	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	2/6/2013	Consider expanding the price substitution policy to include certain HCPCS codes with partial AMP data.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.

OEI-03-12-00670	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	2/6/2013	Consider expanding the price substitution policy to include all HCPCS codes with complete AMP data.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-03-12-00670	Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2011	2/6/2013	Consider seeking a legislative change to require manufacturers of Part B-covered drugs to submit both ASPs and AMPs.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-03-12-00680	CMS Has Not Performed Required Closeouts of Contracts Worth Billions	12/2/2015	CMS should improve coordination and collaboration with NIH	Concur	2020	In Progress	ASU target date 11/2019
OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	CMS should provide Part D plan sponsors with specific guidelines on how to define and count incidents of potential fraud and abuse, related inquiries, and corrective actions.	Concur	2020	In progress	CMS believes that this recommendation is directly tied to other recommendations that the OIG. CMS has made the mandatory reporting of fraud waste and abuse by Medicare Part C and D Plan Sponsors. Modifying the current voluntary reporting of fraud, waste and abuse by Medicare Part C and D Plans to one that would be mandatory in nature would require rulemaking. CMS conducted a voluntary pilot on the effectiveness of reporting Medicare Part C and D plans fraud, waste and abuse efforts.
OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	CMS should share Part D plan sponsors' data on potential fraud and abuse with all sponsors and law enforcement.	Concur	2020	In progress	CMS provides assistance to plans on how to identify FWA, ranging from job aids to in-person training with networking sessions. Collection and analysis of reporting of incidents and profiling high and low reporters is only meaningful in an environment when most or all plans report or reporting is mandatory. The data submitted by part D sponsors and Part C plans can be analyzed with trends identified at that time.
OEI-03-13-00030	Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse	3/3/2014	CMS should review data from Part D plan sponsors to determine why certain sponsors reported especially high or low numbers of incidents of potential fraud and abuse, related inquires, and corrective actions.	Concur	2020	In progress	CMS believes that this recommendation is directly tied to other recommendations that the OIG. CMS has made the mandatory reporting of fraud waste and abuse by Medicare Part C and D Plan Sponsors. Modifying the current voluntary reporting of fraud, waste and abuse by Medicare Part C and D Plans to one that would be mandatory in nature would require rulemaking. CMS conducted a voluntary pilot on the effectiveness of reporting Medicare Part C and D plans fraud, waste and abuse efforts.

OEI-03-13-00050	Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results	4/27/2016	CMS should revise and clarify site visit forms so that they can be more easily used by inspectors to determine whether a facility is operational	Concur	2020	In progress	CMS has drafted new NSVC form. CMS believes that some of the questions on the site visit form are not applicable, which may cause confusion when assessing whether a practice location is operational. Specifically questions 5 and 6 are specific to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) site visits. Since the National Supplier Clearinghouse (NSC) is responsible for conducting DMEPOS site visits, these questions are being removed from the form.
OEI-03-13-00050	Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results	4/27/2016	CMS should ensure that PECOS contains the complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements	Concur	2020	In progress	CMS is continuing the screening risk level clean-up efforts. CMS is working with MACs and the NSC to ensure PECOS contains complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements. CMS expects all planned actions to be completed by the second quarter of fiscal year 2020.
OEI-03-13-00270	Compounded Drugs Under Medicare Part B: Payment and Oversight	4/29/2014	CMS should explore the possibility of conducting descriptive analyses of Part B claims for compounded drugs.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-03-13-00270	Compounded Drugs Under Medicare Part B: Payment and Oversight	4/29/2014	CMS should explore the possibility of requiring providers to identify on the Part B claim the pharmacy that produced the compounded drug.	Non-concur	NA	Awaiting Disposition	CMS position has not changed, continues to non concur with OIG recommendation.
OEI-03-13-00450	MACs Continue to Use Different Methods to Determine Drug Coverage	8/9/2016	CMS should assign a single entity to assist MACs with making coverage determinations	Non-concur	NA	Awaiting Disposition	Per OIG August 2017 Response Memo: we will treat CMS's response as its notification of final action. However, OIG will continue to consider this recommendation unimplemented.
OEI-03-13-00450	MACs Continue to Use Different Methods to Determine Drug Coverage	8/9/2016	CMS should evaluate the cost-effectiveness of edits and medical reviews that are designed to ensure appropriate payments for covered uses on Part B drug claims	Concur	2020	In progress	CMS will share our drug study information with the MACs for consideration when developing and implementing effective mechanisms that ensure appropriate coverage and payment for drug claims.
OEI-03-13-00570	Comparing Average Sales Prices and Average Manufacturer Prices for	3/14/2014	CMS should expand the price substitution policy to include HCPCS codes with partial AMP data.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.

	Medicare Part B Drugs: An Overview of 2012						
OEI-03-13-00570	Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2012	3/14/2014	CMS should expand the price substitution policy to include HCPCS codes with complete AMP data that exceed the threshold in a single quarter.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-03-13-00630	Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPICs and PSCs	9/27/2017	To increase the likelihood of overpayments being recovered, CMS should implement the surety bond requirement for home health providers and consider the feasibility of implementing surety bonds for other providers based on their level of risk	Non-concur	2020	In progress	CMS has not formally made a decision as to whether or not we concur. CMS is currently evaluating how to effectively implement a surety bond requirement while avoiding undue provider burden. The CMS concurs that implementing a surety bond requirement for HHAs may help reduce potential program vulnerabilities. CMS is currently evaluating its options in implementing this requirement. The surety bond rule would be a significant rule and thus subject to the Executive Order “Reducing Regulation and Controlling Regulatory Costs” issued by the President on January 30, 2017. Any further actions regarding a surety bond rule would be undertaken in that context.
OEI-03-13-00630	Enhancements Needed in the Tracking and Collection of Medicare Overpayments Identified by ZPICs and PSCs	9/27/2017	CMS should identify strategies to increase MACs’ collection of ZPIC- and UPIC-referred overpayments	Concur	2020	In progress	CMS working to submit closure notice.
OEI-03-14-00230	Federal Marketplace: Inadequacies in Contract Planning and Procurement	1/20/2015	CMS should ensure that all contracts that are subject to its Contract Review Board requirements undergo these reviews	Concur	2020	In Progress	ASU target date 11/2019
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program	1/16/2018	CMS should ensure that billing provider identifiers are valid and active on all records in the MA encounter data	Concur	2019	In progress	We are in the process of developing specifications for the study

	Oversight, But Improvements Are Needed						
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	CMS should establish and monitor MA encounter data performance thresholds related to MAO's submission of records with complete and valid data	Concur	2019	In progress	CMS is considering the most efficient approach to implementing this edit without compromising the system ability to process an ever increasing volume of encounter data records.
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	CMS should track MAOs' response to reject edits	Concur	2019	In progress	Given the burden on plans and the likelihood that plans would not be able to get all their data in if we required these data, CMS would need to weigh the administrative burden on plans to submit these specific data elements versus intended use for PI purposes
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	CMS should provide targeted oversight of MAOs that submitted a higher percentage of encounter records with potential errors	Concur	2019	In progress	Given the burden on plans and the likelihood that plans would not be able to get all their data if we required these data, CMS would need to weigh the administrative burden on plans to submit these specific data elements versus intended use for PI purposes.
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	CMS should require MAOs to submit ordering and referring provider identifiers for applicable records	Concur	2019	In progress	CMS is in progress on the recommended actions.
OEI-03-15-00060	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	1/16/2018	CMS should ensure that MAOs submit rendering provider identifiers for applicable records	Concur	2019	In progress	CMS is in progress on the recommended actions.

OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	CMS should revise the definition of the device name data element so that the information reported in this field is required to be more specific	Concur	2022	In progress	CMS is working to strengthen validation processes to ensure that actual drug names are reported and are accurate. With respect to devices, a unique device identification system is necessary to validate reported device names, and CMS is exploring various options to incorporate this information.
OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	CMS should ensure that valid national drug codes are reported for drugs.	Concur	2020	In progress	CMS concurs with this recommendation and is working to ensure that reported national drug codes are valid.
OEI-03-15-00220	Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting	8/3/2018	CMS should strengthen validation rules and revise data element definitions so that actual drug and device names must be reported	Concur	2022	In progress	CMS concurs with this recommendation. A unique device identification system is necessary to validate reported device names, and CMS is actively exploring various options to incorporate this information.
OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should ensure that the MEDIC has the ability to require medical records from prescribers of Part D drugs not under contract with plan sponsors, obtaining legislative authority, if necessary.	Concur	2020	In Progress	Should CMS determine to move forward with a rule, it is likely that the rule would become effective no later than the CY21 year.
OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should clarify the MEDIC's authority to require records from pharmacies, pharmacy benefit managers, and other entities under contract with Part C and Part D plan sponsors.	Concur	2020	In Progress	CMS has provided the MEDIC with access to centralized Part C encounter data for specific projects. CMS is continuing to work with the MEDIC to provide access to all Part C encounter data fields, but complete access is likely not technically feasible at this time.
OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should provide the MEDIC centralized access to all Part C encounter data.	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. CMS believes that the most effective means of reducing the burden of the Medicare Part C and Part D enrollment requirement on prescribers and providers is to concentrate our efforts on preventing Medicare Part D coverage of prescriptions written by prescribers who pose an elevated risk to Medicare beneficiaries, and preventing Medicare Part C payment for items and services furnished by providers and suppliers who pose an elevated risk to Medicare beneficiaries.

OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should require that Part C and Part D providers and pharmacies enroll in Medicare.	Concur	2020	In Progress	CMS issued a TDL to clarify the MEDIC's authority to obtain documentation from plans, FDRs and non-contracted prescribers of Part D drugs.
OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should establish measures to assess the MEDIC's effectiveness.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-03-17-00310	The MEDIC Produced Some Positive Results but More Could be Done to Enhance its Effectiveness	7/11/2018	CMS should require plan sponsors to report Part C and Part D fraud and abuse incidents and the corrective actions taken to address them to a centralized system.	Concur	2020	In progress	CMS has revised metrics to ensure it is measuring the effectiveness of the MEDIC in identifying and combating fraud, waste, and abuse. Revised metrics are being incorporated into the MEDIC contract in Spring 2019. CMS is evaluating next steps in response to this recommendation.
OEI-03-17-00360	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2015 Average Sales Prices	9/27/2017	CMS should expand the price-substitution policy	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-03-18-00120	Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices	8/6/2018	CMS should expand the price substitution policy to include additional drugs.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-04-11-00590	Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure	5/20/2016	CMS should require State Medicaid programs to verify the completeness and accuracy of provider ownership information	Non-concur	NA	Awaiting Disposition	CMS does not concur with this recommendation. Although CMS does agree that verifying the completeness and accuracy of provider ownership information is ideal, CMS cannot achieve this ideal state due to the fact that the resources required for successful task completion are not available

OEI-04-12-00280	Questionable Billing for Medicare Ophthalmology Services	9/15/2015	CMS should review providers with questionable billing for ophthalmology services identified by this evaluation and take appropriate action	Concur	2020	Awaiting Disposition	CMS submitted SMRC overpayment information to the OIG
OEI-04-12-00281	Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims	12/22/2014	CMS should Implement additional claims processing edits or improve existing edits to ensure claims are paid appropriately	Concur	2020	Awaiting Disposition	CPI has determined that this vulnerability has been successfully mitigated. Information sent to OIG to close-out recommendation work.
OEI-04-12-00281	Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims	12/22/2014	CMS should determine the appropriateness of ophthalmology claims identified in this report and take appropriate action	Concur	2020	Awaiting Disposition	Closed Implemented 10/16/19
OEI-04-12-00380	CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain	6/16/2016	CMS should require hospitals to submit attestations for all their provider-based facilities	Concur	2020	In progress	CMS is exploring regulatory and subregulatory ways for hospitals to submit information to CMS for all off-campus provider-based services that are paid the higher OPPS payment rates.
OEI-04-12-00380	CMS Is Taking Steps To Improve Oversight of Provider-Based Facilities, But Vulnerabilities Remain	6/16/2016	CMS should take appropriate action against hospitals and their off-campus provider-based facilities that we identified as not meeting requirements	Concur	2020	In progress	CMS working with the MACs to determine providers referred by the OIG are out of compliance with the provider-based requirements.
OEI-04-12-00490	Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals	6/3/2014	CMS should conduct additional analysis to determine the extent to which financial incentives influence LTCH readmission decisions	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.

OEI-05-03-00170	Status of the Rural Health Clinic Program	8/1/2005	CMS should seek legislative authority or administratively require RHC applicants to document need and impact on access to health care in rural underserved areas.	Concur	2020	In progress	Working internally with CMS Office of Legislation for resolution.
OEI-05-10-00200	Early Assessment of Review Medicaid Integrity Contractors	2/21/2012	CMS should improve the quality of data that Review MICs can access for conducting data analysis.	Concur	2020	In Progress	ASU target date 12/2019
OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decision s	3/4/2013	CMS should establish minimum standards requiring sponsors to ensure that safeguards are established to prevent improprieties related to employment by the entity that maintains the P&T committee.	Non-concur	NA	Awaiting Disposition	Per OIG September 2015 Response Memo- OIG continues to consider this recommendation unimplemented. CMS will not be taking any further action.
OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decision s	3/4/2013	CMS should define Pharmacy Benefit Managers (PBM) as entities that could benefit from formulary decisions.	Non-concur	NA	Awaiting Disposition	Per OIG September 2015 Response Memo- OIG continues to consider this recommendation unimplemented. CMS will not be taking any further action.
OEI-05-10-00450	Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decision s	3/4/2013	CMS should oversee compliance with Federal P& T committee conflict-of-interest requirements and guidance.	Non-concur	NA	Awaiting Disposition	CMS will not be taking any further action
OEI-05-12-00080	Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare	8/14/2013	CMS should seek legislative authority to remove Necessary Provider CAHs' permanent exemption from the distance requirement, thus allowing CMS to Reassess these CAHs.	Concur	2020	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

OEI-05-12-00080	Most Critical Access Hospitals Would Not Meet the Location Requirements If Required To Re-enroll in Medicare	8/14/2013	CMS should seek legislative authority to revise the CAH Conditions of Participation to include alternative location-related requirements	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-05-12-00085	Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals	10/7/2014	CMS should seek legislative authority to modify how coinsurance is calculated for outpatient services received at Critical Access Hospitals.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-05-12-00480	Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded	2/18/2014	CMS should seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-05-12-00480	Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded	2/18/2014	CMS seek legislative authority to expand the DRG window to include other hospital ownership arrangements, such as affiliated hospital groups.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-05-12-00610	Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System	9/18/2013	CMS Should Establish a Deadline for When National T-MSIS Data Will Be Available	Concur	2020	In Progress	ASU target date 12/2019

OEI-05-13-00290	CMS Has Yet To Enforce a Statutory Provision Related to Rural Health Clinics	9/11/2014	CMS should issue regulations to ensure that RHCs determined to be essential providers remain certified as RHCs.	Non-concur	NA	Awaiting Disposition	CMS continues to non concur with OIG recommendation.
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data	Concur	2020	In progress	CMS will provide our plan for State-specific targeted assistance on the FCBC to the remaining States that have not implemented federal requirements. CMS expects the actions of this recommendation to be completed by the first quarter of FY20.
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should assist States in overcoming challenges in conducting site visits	Concur	2020	In progress	CMS will provide our plan for State-specific targeted assistance on site visit to the remaining States that have not implemented. Furthermore, CMS is updating the Medicaid Provider Enrollment Compendium (MPEC) to revise the site visit requirement to permit activities that are not on-site visits to constitute site visits. CMS expects the actions of this recommendation to be completed by the first quarter of FY20.
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should assist States in implementing fingerprint-based criminal background checks for all high-risk providers	Concur	2020	In progress	CMS is continuing the screening risk level clean-up efforts. CMS is working with MACs and the NSC to ensure PECOS contains complete and accurate data needed to execute and evaluate CMS's enrollment-screening enhancements. CMS expects all planned actions to be completed by the second quarter of fiscal year 2020
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should develop a central system where States can submit and access screening results from other States	Concur	2019	In progress	The Data Exchange System (DEX) allows SMAs and CMS to exchange information and files related to Medicaid enrollment termination and Medicare enrollment revocation. CMS cannot use DEX to allow States to share enrollment information as it is out of the contractual scope of the system and is not in line with the intent of the system. Instead, CMS provides states with contact information for the individuals within each SMA who can provide screening and enrollment information. States are asked to reach out to those individuals when it is necessary to access screening results from another State. Further, CMS has issued guidance on this topic in the Medicaid Provider Enrollment Compendium as of its original publication date in 2016 (MPEC, section 1.5.3). CMS is aware that States utilize this process quite frequently by contacting other states via email and phone to confirm screening results. This process is currently the most feasible solution. CMS has not created any subgroups, but encourages States to create subgroups amongst themselves to discuss best practice ideas. These types of collaborative tools and processes are routinely encouraged

							through monthly PE TAG calls, provider enrollment conferences, and other conversations with the States. Further, allowing states the flexibility to communicate regarding screening is in line with the CMS strategic goal to usher in a new era of state flexibility and local leadership that provides states and local communities' flexibility so they can design innovative programs that best meet their citizens' unique needs.
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should strengthen minimum standards for fingerprint-based criminal background checks and site visits	Concur	2020	In progress	CMS is currently updating the Medicaid Provider Enrollment Compendium (MPEC) to revise the site visit requirement to permit activities that are not on-site visits to constitute site visits. In regards to FCBC, majority of States that submitted the FCBC compliance plan stated they would be conducting national background checks. CMS will work one-on-one with the states that reported using local background checks to reiterate the importance of conducting national checks. CMS recommended in the final rule that States do a federal/FBI background check, but States have discretion to decide what databases to check against.
OEI-05-13-00520	Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented	5/20/2016	CMS should work with States to develop a plan to complete their revalidation screening in a timely way	Concur	2020	In progress	CMS will provide our plan for targeted assistance to the remaining States that have not completed their revalidation screenings. CMS expects the actions of this recommendation to be completed by the first quarter of FY 20.
OEI-05-14-00430	State Efforts to Exclude 340B Drugs from Medicaid Managed Care Rebates	6/16/2016	CMS should require the use of claim level methods to identify 340B claims	Non-concur	NA	Awaiting Disposition	As of 10/3/2018, OIG considers this closed/unimplemented and has established a new tracking # 399-915-13-02-04975 requiring legislative action.

[OEI-06-09-00091]	Hospital Incident Reporting Systems Do Not Capture Most Patient Harm	1/5/2012	CMS should provide guidance to accreditors regarding survey or assessment of hospital efforts to track and analyze events and should scrutinize survey processes when approving accreditation programs.	Concur	2021	Awaiting Disposition	Given the recent Supreme Court Allina decision, we are unable to provide a timeline for the release of sub regulatory guidance updates. However, because all Medicare-certified hospitals must comply with the hospital conditions of participation, specifically the detailed requirements within QAPI - even though guidance has been delayed, all accreditation organizations with CMS approved deemed status hospital programs are required to survey to standards which meet or exceed these CMS of hospital efforts to track and analyze events continue to happen with our without CMS sub regulatory guidance. Additionally, CMS is actively involved in working through several strategies to improve communication between Accrediting Organizations (AOs) and State Agencies in order to improve overall health and safety of patients. Through our oversight of AOs, CMS must ensure that providers and suppliers that are accredited under an approved AO accreditation program meet the minimum patient safety and quality standards required by Medicare. We are working with AOs whose facilities show an apparent lack of accountability and oversight from the hospital's governing body. The regulatory expectation of a hospital's governing body is to lead and direct quality within their organizations. CMS is working with AOs to improve facility oversight by developing a consistent process for coordinating communications between AOs and the State Agency, Regional Office and Central Office. Given that most of what we are doing requires reg. change now due to Allina, we should at least have an NPRM out for comment that will show GAO we're working on the issue by December 2020.
[OEI-06-10-00520]	Medicare Hospital Outlier Payments Warrant Increased Scrutiny	11/13/2013	CMS should instruct Medicare contractors to increase monitoring of outlier payments	Concur	2019	Awaiting Disposition	CMS believes that its existing guidelines fulfill the recommendation and does not plan to take any new actions, OIG treated CMS' s response as its notification of final action for this recommendation. OIG considers this recommendation unimplemented.
[OEI-06-12-00031]	CMS System for Sharing Information About Terminated Providers Needs Improvement	3/26/2014	CMS should require each State Medicaid agency to report all terminated providers.	Concur	2020	In progress	CMS plans to have plans implemented and updated guidance published in the Medicaid Provider Enrollment Compendium in FY20 Q1.
[OEI-06-14-00010]	Indian Health Service Hospitals: More Monitoring Needed to	10/6/2016	CMS should assist IHS in its oversight efforts by conducting more frequent surveys of hospitals, informing IHS leadership of deficiency citations, and continuing to	Concur	2020	In progress	CMS will continue to provide technical assistance and training to IHS hospitals through the Hospital Engagement Network (HEN) on harm reduction. Additionally, CMS will provide Quality Assurance and Performance Improvement (QAPI) support from the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for two hospitals in

	Ensure Quality Care		provide technical assistance and training				the Great Plains service area. CMS is working with IHS to provide a QIN-QIO focused solely on IHS hospitals. The role of the QIN-QIO will be to solidify the foundational processes that will lead to high quality healthcare in the areas of leadership, staffing, data analytics, clinical standards of care and quality. Supporting documentation to be submitted to outline the expectations of the ROs and demonstrating the frequency of the revised recertification survey schedule.
OEI-06-14-00110	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	AHRQ and CMS should collaborate to create and promote a list of potential rehab hospital events	Concur	2021	In progress	There are six hospitals that fall into this recommendation from OIG that we survey non-deemed hospitals at the same frequency as the deemed hospitals (every three years).
OEI-06-14-00110	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	AHRQ and CMS should raise awareness of adverse events in rehab hospitals and work to reduce harm to patients	Concur	2021	In progress	CMS and AHRQ have discussed this recommendation and it is CMS' understanding that AHRQ will do the required research to generate the list of harms applicable to the rehabilitation hospital setting. It is also CMS' understanding that this commitment has been relayed to the OIG through the appropriate AHRQ channels. Additionally, The QIIG has initiated a Hospital Improvement and Innovation Network Special Project to better understand the harms that occur in inpatient rehabilitation hospitals by studying "high performing" inpatient rehabilitation facilities and culling effective strategies, change concepts and actionable items that will serve as a starting point for quality improvement efforts in these facilities. CMS will share those results with AHRQ for further development of the harms list. CMS and AHRQ are also working to expand the development of the Quality Safety Review System (QSRS) which once implemented will allow for an accurate national sample of harms in IRFs. This system is in development and it is not anticipated that the version inclusive of the IRF setting will be ready in time for the next HIIN contract cycle launch. However, this should support the combined commitment of CMS and AHRQ to reduce harm in the IRF setting in the future and does not preclude the HIIN network from beginning their quality activities.

[OEI-06-14-00110]()	Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries	7/19/2016	CMS should include information about potential events and patient harm in its quality guidance to rehab hospitals	Concur	2021	In progress	CMS-CCSQ Components met in response to continued questions and have coordinated to ensure that the correct component is responding to this request. The Quality Safety and Oversight Group (QSOG) provides guidance to CMS Surveyors for their use. Guidance related to the Quality Assessment Performance Improvement (QAPI) in IRFs has not been released and would need to be cleared by the CMS Administrator. However, other supportive work of this recommendation occur in other parts of the agency. As part of the background work for measures developed and/or implemented in the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP), CMS and its contractors take into consideration gaps in quality, including those associated with adverse events. Within its materials posted for public, stakeholder and provider use, we explain the importance of each measure and the quality gap it is designed to address, such as falls with injuries, preventable readmissions, and healthcare acquired infections. Such materials are posted on CMS's websites which are used by providers for various purposes, including understanding the measures used in the program. Materials related to the IRF QRP can be found on the various tabs of the IRF QRP webpages at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/index.html. For example, information regarding the measures included on the confidential feedback reports (quality measure (QM) reports) is available on the IRF QRP Measures information webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/IRF-Measure-Calculations-and-Reporting-Users-Manual-V30.pdf. In addition, an example of the type of information related to measure specifications, including the purpose and rationale for a quality measure, can be found in the following document available on our webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Final-Specifications-for-IRF-QRP-Quality-Measures-and-Standardized-Patient-Assessment-Data-Elements-Effective-October-1-2018.pdf. Additional documents for the various quality measures are available in the Archives tab of the IRF QRP webpage at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Archives.html. The materials contain information on the data and reports that providers can review related to the IRF QRP quality measures to help drive quality improvement in their facilities. Specifically, providers can download confidential feedback reports to review how they are performing with the measures for use in quality improvement activities, including measures that address adverse events such

							as falls with major injury. Further, as part of the background on those measures that we propose to use through rule making, we explain in detail the importance, including empirical evidence, to support the need for a given quality measure, including those that address adverse events. The public reporting component (IRF Compare) of the IRF QRP was implemented December, 2016. This website displays quality measurement results on patient safety measures such as pressure ulcers and falls. The IRF QRP is used by both patients and providers to better understand the quality provided in each facility. Within the IRF Compare site there is information provided aimed to support quality improvement, such as information that pertains to healthcare associated infections. In addition, the IRF Compare website provides links to additional information about these infections at https://www.cdc.gov/hai/prevent/prevention.html. The Compare website also includes a link for patient safety information at https://www.cdc.gov/hai/patientsafety/patient-safety.html.
OEI-06-16-00380	CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities	6/26/2018	CMS should assess the costs and benefits of collecting and maintaining information regarding the level of care provided by Medicaid-only nursing facilities	Concur	2020	In progress	CMS will instruct the Medicare Contractors to review place-of-service codes submitted by durable medical equipment suppliers during noncovered skilled nursing facility stays. CMS will recover any inappropriate reimbursements associated with these claims consistent with agency policy and procedures and will provide targeted education to durable medical equipment suppliers that are found to be frequently submitting inaccurate place of service codes.
OEI-06-16-00380	CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities	6/26/2018	CMS should assess the costs and benefits of improving oversight of no-payment bills submitted by SNFs	Concur	2020	In progress	CMS will evaluate ways to improve oversight of no-payment bills submitted by skilled nursing facilities including assessing whether it would be cost effective to implement a process similar to the one that OIG used for this review to identify noncovered stays for which skilled nursing facilities did not submit the required no-payment bills and provide targeted education regarding submission of no-payment bills to skilled nursing facilities found to have high numbers of missing bills.

OEI-06-16-00380	CMS Did Not Detect Some Inappropriate Claims for Durable Medical Equipment in Nursing Facilities	6/26/2018	CMS should improve oversight of place-of-service codes submitted by DME suppliers for DME provided during noncovered SNF stays	Concur	2020	In progress	CMS will evaluate ways to improve oversight of place-of service codes submitted by durable medical equipment suppliers for Medicaid-only nursing facility stays.
OEI-07-08-00150	Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents	5/4/2011	CMS should facilitate access to information necessary to ensure accurate coverage and reimbursement determination	Non-concur	NA	Awaiting Disposition	Non-Concur. CMS will not be taking any action
OEI-07-09-00290	CMS Reporting to the Healthcare Integrity and Protection Data Bank	9/1/2010	CMS should report all adverse actions as required.	Concur	2020	In progress	CMB1024:M1026S is in the process of establishing an MOU/IEA between HRSA and CMS; therefore, we anticipate that NPDB reporting will begin by the end of the second quarter of FY 20.
OEI-07-10-00410	CMS Has Not Promulgated Regulations To Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics	10/10/2012	CMS should promulgate regulations to implement the BIPA payment requirements.	Concur	2020	In progress	CMS will use the same or similar forums in its notification of final action: Every 6 week Open Door Forum presentations; Town Hall meetings; ListServe messages; Claim remittance advice footers with important educational information for the DMEPOS supplier; MLN Matters articles; Fact Sheets; Press Releases; Webinars; Monthly conference calls with DMEPOS deemed accreditation organizations.
OEI-07-12-00250	Replacement Schedules for Medicare Continuous Positive Airway Pressure Supplies	6/24/2013	CMS should review the CPAP supply replacement schedule and revise the national coverage determination for CPAP therapy for OSA or request that the DME MACs revise their LCDs as appropriate	Non-concur	NA	Awaiting Disposition	Non-Concur. CMS will not be taking any action
OEI-07-12-00710	State Medicaid Program Efforts to Control Costs for Disposable Incontinence Supplies	1/24/2014	CMS should encourage State Medicaid programs to seek further cost savings for disposable incontinence supplies.	Concur	2020	In Progress	ASU target date 12/2019

OEI-07-13-00120	Not All States Reported Medicaid Managed Care Encounter Data as Required	7/3/2015	CMS should monitor encounter data to ensure States report data for all managed care entities	Concur	2020	In Progress	CMS is updating regulatory requirements for managed care data in the NPRM CMS-2408-P.
OEI-07-13-00480	Iowa Has Shifted Medicare Cost-Sharing for Dual Eligibles to the Federal Government	4/4/2014	CMS should require States to submit more detailed eligibility information	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-07-13-00480	Iowa Has Shifted Medicare Cost-Sharing for Dual Eligibles to the Federal Government	4/4/2014	CMS should seek legislative change to prevent States from using State Supplementary Payments to shift Medicare Part B premium costs for FBDEs to the Federal Government.	Non-concur	NA	In progress	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-09-12-00351	Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports	9/28/2015	CMS should require ambulance suppliers to include the National Provider Identifier of the certifying physician on transport claims that require certification	Concur	2019	Awaiting Disposition	CMS submitted documentation for closure of the recommendation to OIG.
OEI-09-12-00351	Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports	9/28/2015	CMS should determine whether a temporary moratorium on ambulance supplier enrollment in additional geographic areas is warranted	Concur	2020	In progress	Pending regulation. CMS-6058-P, published March 2016, contained a provision requiring inclusion of the NPI of ordering, certifying, referring, or prescribing physicians or eligible professionals on Part B claims, including ambulance services. 6058-F does not currently include this provision. CMS also is considering regulation that would change certification requirements for non-emergency ambulance transports and render this recommendation moot.
OEI-09-14-00020	Challenges Appear to Limit States' Use of Medicaid Payment Suspensions	9/5/2017	CMS should provide additional technical assistance to help Medicaid agencies fully utilize Medicaid payment suspensions as a program integrity tool	Concur	2020	In progress	CMS continues to provide technical assistance to state Medicaid agencies on the use of the payment suspension tool and will follow-up with Medicaid agencies when appropriate to determine if additional technical assistance is needed. CMS will be using its focused State Program Integrity Reviews to better inform which States should be engaged for more directed technical support. CMS will continue to review reported data on payment suspensions

OEI-09-14-00440	Inconsistencies in State Implementation of Correct Coding Edits May Allow Improper Medicaid Payments	4/15/2016	CMS should take appropriate action to ensure that States fully implement the NCCI edits	Concur	2020	In progress	CMS is committed to improving the Medicaid NCCI and will work with the states to support their implementation of the NCCI edits. In addition, CMS will explore the use of incentives and other efforts to bring states into compliance.
OEI-09-16-00410	Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials	9/25/2018	CMS should address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage	Concur	2019	Awaiting Disposition	CMS account managers meet with MAOs on a regular basis to provide technical assistance and conduct ad-hoc meetings to address outliers and issues that need immediate attention. Corrective actions are taken when program non-compliance is identified. Sponsor selection for audit includes audit referrals as discussed on page 6 of the 2017 Part C and Part D Program Audit and Enforcement Report. https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/2017ProgramAuditEnforcementReport.pdf .
OEI-09-16-00410	Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials	9/25/2018	CMS should provide beneficiaries with clear, easily accessible information about serious violations by MAOs	Concur	2019	Awaiting Disposition	CMS also concurred with the second recommendation to address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage. CMS noted that its audit process addresses individual poor-performing MAOs, but it did not indicate the actions that it plans at the program-level to address these persistent problems. To address these concerns at a program-level, CMS provided technical assistance to Medicare Advantage Organizations (MAOs) by posting a frequently asked questions document that provides clarifications for the industry. CMS also release the final Parts C & D Enrollee Grievances Organization/Coverage Determinations, and Appeals Guidance which provides guidance on notification requirements, timeframes, outreach, and clinical decisions. Best practices are also included in this guidance to provide additional training. In addition, OIG recommended that CMS consider applying additional aggravating factors to civil money penalties (CMPs) for these violations. CMS already applies aggravating factors to CMPs for repeat violations for inappropriate delay/denial of Part C medical services. CMS recently released a revised CMP calculation methodology for 2019 that would add an a per enrollee aggravating factor when there was an inappropriate denial of a Part C medical service and the enrollee never received the care. CMS released the updated guidance noted below in February 2019 and released a revised CMP methodology in March 2019.
OEI-09-16-00410	Medicare Advantage Appeal Outcomes and	9/25/2018	CMS should enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low	Concur	2019	Awaiting Disposition	CMS conducted interviews that focused on assessing: • Participants' understanding of and reactions to text related to sanctioned plans; • Participants' understanding of and reactions to an icon and explanatory text related to CMPs;

	Audit Findings Raise Concerns About Service and Payment Denials		appeal rates, and take corrective action as appropriate				Test results showed that adding this information was misleading and did not provide beneficiaries with accurate information on an MAO's current performance.
OEI-12-12-00210	Least Costly Alternative Policies: Impact on Prostate Cancer Drugs Covered Under Medicare Part B	11/21/2012	We recommend that CMS consider seeking legislative authority to implement Least Costly Alternative (LCA) policies for Part B drugs under appropriate circumstances.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-12-12-00260	Medicare Could Collect Billions If Pharmaceutical Manufacturers Were Required To Pay Rebates for Part B Drugs	9/9/2013	CMS should examine the additional potential impacts of establishing a prescription drug rebate program under Medicare Part B and, if appropriate, seek legislative change.	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.
OEI-12-13-00040	Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs	7/21/2014	CMS should finalize the implementation of automated ASP-related procedures by using AMP-related processes as a model, and subsequently require all manufacturers to submit ASPs through the automated system.	Concur	2020	In progress	The system is expected to be open for business for April submissions due April 30,2019. We are planning dual submissions (manufacturers will report in the system and the former way). If all goes well, July reporting will be solely in the system, therefore expected completion date can be August 2020.
OEI-12-17-00260	Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries	11/21/2017	CMS should seek a legislative change that would provide the agency flexibility to determine when noncovered versions of a drug should be included in Part B payment amount calculations	Non-concur	NA	Awaiting Disposition	CMS lacks statutory authority to implement the recommendation, and will consider this recommendation when developing future legislative proposals.

GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, OMHA, or DAB to modify the various Medicare appeals data systems to capture the amount, or an estimate, of Medicare allowed charges at stake in appeals in Medicare Appeals System (MAS) and Medicare Operations Division Automated Case Tracking System (MODACTS).	Concur	NA	In Progress	The DAB continues to explore the feasibility of tracking allowed amounts at Level 4. However, one constraint for the DAB is access to this type of data; this data must be provided to the DAB by prior levels or included in the record on appeal. In the meantime, DAB has started recording and tracking billed amounts in MODACTS, based on the information that is available in the record for each appeal.
GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, OMHA, or DAB to modify the various Medicare appeals data systems to collect consistent data across systems, including appeal categories and appeal decisions across MAS and MODACTS	Concur	2018	Awaiting Disposition	CMS recommends closure on both recommendation 3 & 4 based on the following: MAS CR 747 was released in November 2016 and included revised Level 3 Appeal Categories. This functionality allows for consistent appeal categories at case closure when ECAPE transmits closed Level 3 appeals back to the appeals system of records, MAS. As of the end of April 2017, all Part A MACs were successfully onboarded to MAS. Since CMS' last reporting date, all MACs had passed their transition period and had attested to readiness in MAS and their desire to continue processing within the MAS environment and not roll back to their previous legacy systems. CMS continues efforts to seek funding for onboarding the remaining MACs (Part B and DME) onto MAS. Recently, CMS received FY18 funding for a pilot to partially onboard 1 Part B and 1 DME MAC to MAS for data collection, reporting, and case file transfers only. With this approach, MACs would continue to be able to innovate and experience in-house developed operational efficiencies using their internal workflow and correspondence systems, while also allowing CMS to explore enhanced monitoring of MAC Part B and DME workload. This solution will control MAC operational costs by incrementally allowing for seamless integration into their current workflow and not negatively impact current MAC operating budgets. Web services would assist MACs with updating MAS with data from their internal systems. To account for the complexity of incorporating this new type of workload in MAS, this pilot would allow all MAC jurisdictions to assist in the development of business requirements. In addition, as of the most recent MAS release in May 2018, CMS implemented CR 752 and the functionality to allow MAC users visibility into appeals histories at Levels 1, 2, and 3, associated to their organization's contract. This will greatly assist in data reporting consistency and allows MACs the ability to report

							on cases promoted to Level 3 that may not have been processed within MAS by their organization, but rather through a legacy system or the previous MAC jurisdiction contract holder that was uploaded to MAS by a Level 2 QIC contractor." The DAB continues to work towards developing system interoperability with OMHA's ECAPE system, which will help standardize and integrate data between Levels 3 and 4. Currently, the DAB is working with its IT contractor to developed APIs capable of importing and exporting data from ECAPE. In addition, the DAB actively participated in "IT Sprint," an interagency project led by the HHS Office of the Chief Technology Officer, which explored ways to integrate appeals data across all levels of review. Most recently, the project developed a prototype for a dashboard that would enable various stakeholders to obtain the status of individual or collective claims. The DAB has also established connectivity with CMS contractors for the electronic transfer and upload of claim files for appealed cases.
GAO-16-771	Electronic Health Information: HHS Needs to Strengthen Security and Privacy Guidance and Oversight	9/26/2016	To improve the effectiveness of HHS guidance and oversight of privacy and security for health information the Secretary of Health and Human Services should establish and implement policies and procedures for sharing the results of investigations and audits between OCR and Centers for Medicare & Medicaid Services to help ensure that covered entities and business associates are in compliance with the Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act.	Concur	2020	In Progress	Upon the completion of the last Medicare meaningful use audit, CMS shall obtain from the HITECH meaningful use audit contractor within 14 business days (but no later than 10/31/17) a report of all providers that failed a meaningful use audit and the "protection of electronic health information" measure was deemed not met. The report will be vetted to ensure the providers identified as not having met the "protection of electronic health information" measure were also not associated with a HITECH meaningful use appeal, which may have reversed the audit determination of not met for that measure. On October 30, 2017 the Meaningful Use Audit Contract was closed. In mid-November 2017, Office of Financial Management transferred all data containing results of meaningful use audits including HIPAA compliance to the Centers for Clinical Standards and Quality (CCSQ).

GAO-14-207	Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care	3/6/2014	To ensure that CMS and ONC can effectively monitor the effect of the EHR programs and progress made toward goals, the Secretary of Health and Human Services should direct the agencies to develop performance measures to assess outcomes of the EHR programs--including any effects on health care quality, efficiency, and patient safety and other health care reform efforts that are intended to work toward similar outcomes.	Concur	2020	Awaiting Disposition	In its latest open recommendation update, ONC noted, in-depth, efforts to implement this recommendation, including: (1) regularly/publically reporting on how program participants are progressing in the program and related impacts; (2) funding a series of external program evaluations designed to assess the impact of the programs funded under HITECH, including the EHR Incentive Programs; and, (3) continuing to explore potential outcome measures to incorporate into EHR programs. GAO responded to ONC's update noting "to fully implement this recommendation, CMS needs to develop performance measures that enable the agency to assess whether the Promoting Interoperability programs are improving outcomes, . . ." CMS has indicated that the new scoring submission window ends in the Spring of 2020 and the final data, for the first year, should be available by late 2020.
GAO-14-207	Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care	3/6/2014	To ensure that CMS and ONC can effectively monitor the effect of the EHR programs and progress made toward goals, the Secretary of Health and Human Services should direct the agencies to use the information these performance measures provide to make program adjustments, as appropriate, to better achieve program goals.	Concur	2021	Awaiting Disposition	In addition to actions taken in response to recommendation GAO-14-207-2, to implement recommendation GAO-14-207-3, the information gathered through the monitoring activities noted above was used to inform ONC and CMS programs. For example, information collected was regularly presented to ONC's Federal Advisory Committees to inform their decision-making. CMS and ONC have continued to leverage information gathered through previously noted program monitoring activities to inform rulemaking necessary to implement requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the 21st Century Cures Act (CURES). Both of these legislations build upon the requirements under HITECH and thus might alter the anticipated outcomes of current programs going forward. GAO responded to ONC's update noting "to fully implement this recommendation, CMS needs to develop outcome-oriented performance measures and then demonstrate it is using them to make appropriate program adjustments. . . ." CMS indicated that they expect to be able to close this recommendation once HHS has identified the performance based measures. CMS will not receive the 2019 reporting period data until spring of 2020 and the final validated data until late 2020.

GAO-17-184	Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings	2/27/2017	To improve efforts to promote EHR use and electronic exchange of health information in post-acute care settings, the Secretary of Health and Human Services should direct the Centers for Medicare & Medicaid Services (CMS) and ONC to evaluate the effectiveness of HHS's key efforts to determine whether they are contributing to HHS's goal for increasing the use of EHRs and electronic exchange of health information in post-acute care settings.	Concur	2019	Awaiting Disposition	In its latest open recommendation update, ONC noted, in-depth, the efforts taken to implement this recommendation, including but not limited to, noting ONC conducted activities to evaluate HIT adoption and interoperability for PAC settings, including conducting and analyzing the results of 3 surveys regarding rates of interoperability among skilled nursing facilities and home health agencies. These surveys established important baseline data for EHR adoption and interoperability by skilled nursing home and home health; the results of these analyses were published by ONC in 2 data briefs published in 2017 and 2018; and, ONC presented the results of these analyses to CMS and the public. Also in July 2015, ONC issued 12 two-year cooperative agreements to state-designated entities and state government agencies under the Advance Interoperable Health Information Technology Services to Support Health Information Exchange (AHIE) program. The awards funded efforts to provide training, education, and technical assistance to support clinical and non-clinical caregivers with incorporating HIE into their existing workflows. The goal was to leverage investments and lessons learned from the initial State HIE projects to increase the adoption and use of interoperable HIT to improve care coordination. Each awardee was asked to develop a set of measures unique to their projects that would demonstrate their progress toward these milestones and an evaluation of awardee efforts was also conducted. ONC believes it has addressed the recommendations made in the GAO report that are within ONC's authority and considers the recommendation fully implemented. In August 2019 CMS submitted the Data Element Library response to GAO. It is our understanding that ONC will provide a response regarding the State Medicaid matching funds and additional responses related to their efforts. The program area is hopeful that this closes out both recommendations of this audit for CMS.

GAO-17-184	Electronic Health Records: HHS Needs to Improve Planning and Evaluation of Its Efforts to Increase Information Exchange in Post-Acute Care Settings	2/27/2017	To improve efforts to promote EHR use and electronic exchange of health information in post-acute care settings, the Secretary of Health and Human Services should direct CMS and ONC to comprehensively plan for how to achieve the department's goal related to the use of EHRs and electronic information exchange in post-acute care settings. This planning may include, for example, identifying specific actions related to post-acute care settings and identifying and considering external factors.	Concur	2019	Awaiting Disposition	ONC noted the following in its latest open recommendation update. In 2015, ONC published a federal strategic plan to advance the adoption and interoperability of HIT, including in post-acute care (PAC) settings: Federal Health IT Strategic Plan 2015 – 2020 (the Plan). Contributors to the Plan included representatives from across the federal government, including CMS. The Plan: (1) addresses the federal HIT strategy for all health care industry segments that are health information exchange partners, including long-term care and post-acute; (2) explains how the federal government is working to achieve the mission of 'improving the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most'; (3) applies broadly to stakeholders across the care continuum, including PAC providers, and aims to modernize the U.S. HIT infrastructure so individuals, providers, and communities can use it to help achieve health and wellness goals; (4) includes goals, objectives, and strategies intended to drive the actions needed to improve HIT adoption and PAC interoperability; and, (5) states "long-term and post-acute care plays an integral role in helping to keep individuals healthy and have numerous situations that necessitate collaboration and sharing of information with the greater health community." ONC has also taken actions to advance HIT adoption and interoperability for PAC providers through outreach/collaboration, supports for HIT adoption, and standards/initiatives specific to PAC.ONC believes it has addressed the recommendations made in the GAO report that are within ONC's authority and considers the recommendation fully implemented. In August 2019 CMS submitted the Data Element Library response to GAO. It is our understanding that ONC will provide a response regarding the State Medicaid matching funds and additional responses related to their efforts.The program area is hopeful that this closes out both recommendations of this audit for CMS.
GAO-17-5	Health Care Quality: HHS Should Set Priorities and Comprehensively Plan Its Efforts to Better Align Health Quality Measures	10/13/2016	To make it more likely that HHS will achieve its goals to reduce quality measure misalignment and associated provider burden, the Secretary of HHS should direct CMS and the Office of the National Coordinator for Health Information Technology to prioritize their development of electronic quality measures and associated standardized data elements on the specific quality measures needed for the core	Concur	2020	Awaiting Disposition	CMS does prioritize the development of electronic quality measures and associated standardized data elements on the specific quality measures needed in the cores sets. We have highlighted leveraging the Core Quality Measures Collaborative in our strategic approach for measure development priorities for MACRA, as noted in the CMS Quality Measure Development Plan (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf). The following section and language throughout the MDP is documentation of that prioritization: "CMS intends to prioritize the development of electronic measures in a manner that ensures relevance to patients, improves measure quality, increases clinical data

			measure sets that CMS and private payers have agreed to use.				availability, accelerates development cycle times, and drives innovation. Specifically, CMS, in concert with ONC and the private sector, is championing electronic measure development in the areas of standards, tools, and processes that are open to all measure developers." In addition, we anticipate soon awarding an Eligible Clinician (EC) eCQM maintenance and development contract where the contractor shall identify clinical quality measure concepts for eCQMs that reflect the following CMS priorities: 1) improve quality, safety, and efficiency and reduce health disparities, 2) engage patients and families, 3) improve care and coordination, 4) ensure adequate privacy and security protections for personal health information, and 5) improve population and public health. Measure concepts will be for the EC setting as well as for other health care settings, such as post-acute care setting like skilled nursing facilities, home health, and dialysis facilities. We note that up to 4 new (de novo or retooled) Eligible Clinician eCQMs may be developed during each period of performance of the contract, according to the QPP, Agency and HHS needs and priorities. Although CMS has implemented measures from the Core Quality Measures Collaborative's agreed-upon measure sets, ONC understands that only some of the measures across all of the agreed-upon core sets have been fully developed and specified for EHR reporting. ONC has implemented the 2015 Edition Health IT Certification Criteria (2015 Edition) and its associated testing and certification procedures to support the efforts of CMS and other measure developers who are prioritizing development of core measures, including private payers and clinical specialty societies. Certification to the 2015 Edition ensures a health IT product is capable of capturing and exchanging a defined catalog of data elements in conformance with interoperability standards, all identified in our regulations. Thus, the 2015 Edition provides a foundational set of standardized data elements that CMS and other measure developers can use to develop and specify additional measures for EHR reporting. ONC continues to prioritize interoperability of health data to support patient choice, clinical care, public health, value-conscious purchasing and improved care value. ONC does not plan to take further action(s), other than those actions previously taken, in response to this recommendation. ONC believes efforts to prioritize CMS' development of measures from the core measure sets that they and private payers have agreed to use should be addressed by CMS.

GAO-16-366	Medicare Fee-For-Service: Opportunities Remain to Improve Appeal Process	6/9/2016	To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, the Secretary of Health and Human Services should direct CMS, Office of Medicare Hearings and Appeals (OMHA), or Departmental Appeals Board (DAB) to modify the various Medicare appeals data systems to collect information on the reasons for appeal decisions at Level 3.	Concur	2020	Awaiting Disposition	OMHA recommends closure on this recommendation. In the July 2017 interim release of the Electronic Case Adjudication and Processing Environment (ECAPE) system, OMHA added a "Reason for Disposition" data field for most dispositions issued by an adjudicator. Because the "Reason for Disposition" data field limits the number of reasons that can be selected, OMHA added more categories in later releases. As of November 2019, ECAPE has been implemented in all of OMHA's field offices and its satellite office. Information on the reasons for Level 3 appeal decisions can currently be reported within ECAPE. DAB recently added new data fields and case categories to its case management system to capture more detail about pending cases, including the reasons for ALJ dismissals at level 3. In addition, DAB continues to work towards developing system interoperability with ECAPE. Once baseline interoperability is established, DAB will work with OMHA to explore the feasibility of incorporating level 3 "Reason for Disposition" data into its new system.

Appendix 2: OIG-GAO Closed, Unimplemented Recommendations

Report Number	Report Title	Report Date	Recommendation Text	Implementation Status	Reason for non-implementation
GAO-01-816	Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated	8/22/2001	To help ensure that services are provided in the most appropriate setting, the Administrator of CMS should exclude services from the PPS if they meet the exclusion criteria, regardless of where they are provided.	Closed, Unimplemented	Requires legislative action
GAO-01-816	Skilled Nursing Facilities: Services Excluded From Medicare's Daily Rate Need to be Reevaluated	8/22/2001	To refine and adjust the SNF PPS and to ensure adequate beneficiary access to appropriate medical services, the Administrator of CMS should develop a strategy to collect and analyze cost and utilization data on all services provided to Medicare beneficiaries during a SNF stay.	Closed, Unimplemented	Requires legislative action

GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To ensure the success of the agency's IT modernization, the Administrator of CMS and its senior management should become more involved in IT planning and management efforts, and thus elevate the priority given to these efforts throughout the agency.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To improve development and implementation of the agency's enterprise architecture, the Administrator should direct center and administrative unit officials to complete, in conjunction with the Office of Information Services, the enterprise architecture documentation, particularly of the business functions, information flows, and data elements for the systems for which their respective units are responsible.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To improve development and implementation of the agency's enterprise architecture, the Administrator should direct the Chief Information Officer (CIO) to specify in a migration plan the priorities for, and sequencing of, IT projects.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To improve the investment management process, the Administrator of CMS should require that major IT projects undergo a technical review before the agency approves them for further development.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To improve the investment management process, the Administrator of CMS should direct the CIO and the Federal Management Investment Board to develop sufficient information to monitor the status of IT projects.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-01-824	Medicare: Information Systems Modernization Needs Stronger Management and Support	9/20/2001	To improve the investment management process, the Administrator of CMS should establish a systematic process for evaluating completed IT projects that includes cost, milestone, and performance data.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-116	Civil Fines and Penalties Debt: Review of CMS' Management and Collection Processes	12/31/2001	The Administrator of CMS should establish and implement formal written debt collection policies and procedures for handling instances in which a discount greater than 35-percent is allowed, including the documentation, review, and approval of such settlements.	Closed, Unimplemented	Non-concur

GAO-02-249	Medicare: Communications with Physicians Can Be Improved	2/27/2002	In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should establish new performance standards for carrier call centers that emphasize providing complete and accurate answers to physician inquiries. Carriers' monitoring of their carrier call center operations should also be expanded to assure that these performance standards and policies are followed.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-249	Medicare: Communications with Physicians Can Be Improved		In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should set standards and provide technical assistance to carriers to promote consistency, accuracy, and user-friendliness of carrier Web sites, which should be limited to local Medicare information and should be designed to link to CMS's Web site for national program information.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-249	Medicare: Communications with Physicians Can Be Improved	2/1/2002	In order to improve its assistance to, and oversight of, its Medicare carriers' physician communications efforts, the administrator of CMS should adopt a standard approach that would promote the quality, consistency, and timeliness of Medicare communications while also strengthening CMS's management and oversight. Specifically, CMS should strengthen its contractor evaluation and management process by relying on expert teams to conduct more substantive contractor performance evaluation reviews on all physician communications activities.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should review the adequacy of current state efforts to ensure the accuracy of MDS data, and provide, where necessary, additional guidance, training, and technical assistance.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should monitor the adequacy of state MDS accuracy activities on an ongoing basis, such as through the use of the established federal comparative survey process.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-279	Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities	2/15/2002	With the goal of complementing and leveraging the considerable federal and state resources already devoted to nursing home surveys and to separate MDS accuracy review programs, the administrator of CMS should provide guidance to state agencies and nursing homes that sufficient evidentiary documentation to support the full MDS assessment be included in residents' medical records.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-300	Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	The CMS administrator should restructure oversight control activities by using comprehensive Medicaid payment data that states must provide in the legislatively mandated national Medicaid Statistical Information System database.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-300	Medicaid Financial Management: Better Oversight Needed of State Claims for Federal Reimbursement	1/10/2002	The CMS administrator should develop mechanisms to routinely monitor, measure, and evaluate the quality and effectiveness of financial oversight, including audit resolution, by revising Division of Audit Liaison audit tracking reports to ensure that all audits with Medicaid related findings are identified and promptly reported to the regions for timely resolution.	Closed, Unimplemented	Non-concur
GAO-02-300	Medicaid Financial Management: Better Oversight Needed of State Claims for Federal Reimbursement	2/28/2002	The CMS administrator should establish mechanisms to help ensure accountability and clarify authority and internal control responsibility between regional office and headquarters financial managers by developing a written plan and strategy, which clearly defines and communicates the goals of Medicaid financial oversight and responsibilities for implementing and sustaining improvements.	Closed, Unimplemented	Non-concur
GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	The CMS administrator should restructure oversight control activities by using comprehensive Medicaid payment data that states must provide in the legislatively mandated national Medicaid Statistical Information System database.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	The CMS administrator should develop mechanisms to routinely monitor, measure, and evaluate the quality and effectiveness of financial oversight, including audit resolution, by revising Division of Audit Liaison audit tracking reports to ensure that all audits with Medicaid related findings are identified and promptly reported to the regions for timely resolution.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-300	Medicaid Financial Management: Better Oversight of State Claims for Federal Reimbursement Needed	2/28/2002	The CMS administrator should establish mechanisms to help ensure accountability and clarify authority and internal control responsibility between regional office and headquarters financial managers by developing a written plan and strategy, which clearly defines and communicates the goals of Medicaid financial oversight and responsibilities for implementing and sustaining improvements.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-312	N+E50:H67ursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	To better protect nursing home residents, the Centers for Medicare and Medicaid Services (CMS) Administrator should ensure that state survey agencies immediately notify local law enforcement agencies or Medicaid Fraud Control Units when nursing homes report allegations of resident physical or sexual abuse or when the survey agency has confirmed complaints of alleged abuse.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	To better protect nursing home residents, the CMS Administrator should accelerate the agency's education campaign on reporting nursing home abuse by (1) distributing its new poster with clearly displayed complaint telephone numbers and (2) requiring state survey agencies to ensure that these numbers are prominently listed in local telephone directories.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	To better protect nursing home residents, the CMS Administrator should systematically assess state policies and practices for complying with the federal requirement to prohibit employment of individuals convicted of abusing nursing home residents and, if necessary, develop more specific guidance to ensure compliance.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-312	Nursing Homes: More Can Be Done to Protect Residents from Abuse	3/1/2002	To better protect nursing home residents, the CMS Administrator should shorten the state survey agencies' time frames for determining whether to include findings of abuse in nurse aide registry files.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should baseline the current costs of the service being outsourced, including the cost of internal agency operations.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should perform an analysis of expected costs and benefits.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-329	Desktop Outsourcing: Positive Results Reported, but Analyses Could Be Strengthened	3/29/2002	To provide for adequate justification of any future seat management investments, the Secretary of the Treasury; Administrators for NASA and CMS; and Directors of the Peace Corps, ATF, and DLA should each ensure that existing federal policy and guidance for information technology investments be followed when considering investments in information-technology-service outsourcing. Specifically, for future seat management investments, the agencies should perform an analysis of risks, including developing plans to mitigate risks identified.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	To improve the utility of the audit reports and usefulness of their findings, the Centers for Medicare and Medicaid Services (CMS) Administrator should fully implement plans to calculate the net effect by plan and potential impact of Adjusted Community Rate Proposal (ACRP) audit findings and adjustments.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	To improve the utility of the audit reports and usefulness of their findings, the CMS Administrator should develop and implement a follow-up mechanism to address the audit findings in a timely manner.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-33	Medicare+Choice Audits: Lack of Audit Follow-up Limits Usefulness	10/9/2001	To improve the utility of the audit reports and usefulness of their findings, the CMS Administrator should communicate to each Managed Care Organizations (MCO) specific corrective actions needed for future ACRP submissions.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-02-382	Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues	7/19/2002	To strengthen the ability of the HHA survey process to identify and address problems that affect the quality of care, the Administrator of CMS should ensure that resources are adequate for states to fully comply with the requirement to survey all HHAs at least once every 36 months and certain HHAs more frequently.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should amend the approval of Arizona's Health Insurance Flexibility and Accountability waiver to prevent future use of SCHIP funds on childless adults.	Closed, Unimplemented	Non-concur
GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	To ensure that SCHIP funds are spent only for authorized purposes, the Secretary of Health and Human Services should deny any pending or future state proposals to spend SCHIP funds for this purpose.	Closed, Unimplemented	Non-concur
GAO-02-817	Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns	7/12/2001	To meet its fiduciary responsibility of ensuring that section 1115 waivers are budget neutral, the Secretary of Health and Human services should reconsider Utah and Illinois's budget neutrality justifications, in light of GAO's conclusions that certain costs were inappropriate or impermissible and, to the extent appropriate, adjust the limit on the federal government's financial obligation for these waivers.	Closed, Unimplemented	Non-concur
GAO-02-963	Medicare Hospital Payments: Refinements Needed to Better Account for Geographic Differences in Wages	9/30/2002	To improve the adequacy of Medicare's labor cost adjustments, the Administrator of the Centers for Medicare and Medicaid Services should refine the geographic areas used to more accurately reflect the labor markets in which hospitals compete for employees and the geographic variation in hospitals' labor costs. This could include separating large towns in a state into their own labor market area and removing certain outlying counties in metropolitan statistical areas from the metropolitan geographic area if they exhibit wage costs that are significantly different from the rest of the metropolitan area.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-175	Medicare: Divided Authority for Policies on Coverage of Procedures and Devices Results in Inequities	4/11/2003	To ensure that all Medicare beneficiaries are treated equitably, the Administrator of CMS should eliminate the ability of claims administration contractors to develop new coverage policies for procedures and devices that have established codes.	Closed, Unimplemented	Non-concur

GAO-03-185	Medicare Provider Enrollment: Opportunities to Enhance Program Integrity Efforts	3/17/2003	To facilitate improvements in program integrity, the CMS Administrator should propose legislation permitting the reassignment of benefits to staffing companies that retain contractor physicians to treat Medicare beneficiaries and requiring that these companies seek enrollment in Medicare.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-187	Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature	10/31/2002	To ensure that publicly reported quality indicator data accurately reflect the status of quality in nursing homes and fairly compare homes to one another, the Administrator of CMS should delay the implementation of nationwide reporting of quality indicators until there is greater assurance that the quality indicators are appropriate for public reporting--including the validity of the indicators selected and the use of an appropriate risk-adjustment methodology--based on input from the NQF and other experts and, if necessary, additional analysis and testing.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-187	Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature	10/31/2002	To ensure that publicly reported quality indicator data accurately reflect the status of quality in nursing homes and fairly compare homes to one another, the Administrator of CMS should delay the implementation of nationwide reporting of quality indicators until a more thorough evaluation of the pilot is completed to help improve the initiative's effectiveness, including an assessment of the presentation of information on the Web site and the resources needed to assist consumers' use of the information.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	To better ensure that state survey and complaint activities adequately address quality-of-care problems, the Administrator of CMS should require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-03-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	To better ensure that states comply with statutory, regulatory, and other CMS nursing home requirements designed to protect resident health and safety, the Administrator of CMS should further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for making administrative processes, such as file tracking and transfer, compatible across all appeals bodies.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for negotiating responsibilities and strategies for reducing the backlog of pending cases, especially at OHA and the MAC, and establish the priority for adjudicating pre-BIPA cases relative to BIPA-governed cases.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-03-841	Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities	9/29/2003	The Secretary of Health and Human Services and the Commissioner of SSA should create an interagency steering committee with representatives from CMS, the carriers, OHA, and the MAC to serve as an advisory body to the Secretary of Health and Human Services and the Commissioner of SSA responsible for establishing requirements for reporting specific and comparable program and performance data to CMS, SSA, and HHS so that management can identify opportunities for improvement, and determine the resource requirements necessary to ensure that all appeals bodies will be able to meet BIPA's requirements.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-103R	Medicare: Discrepancy in Hospital Outpatient Prospective Payment System Methodology Leads to Inaccurate Beneficiary Copayments and Medicate Payments	10/6/2003	For the purpose of calculating the 2004 OPPS beneficiary copayment amounts, the Administrator of CMS should first apply the 2002 copayment methodology to the 2003 APCs for which beneficiaries were inaccurately charged. The 2004 copayment amounts should then be based on these revised 2003 copayment amounts.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-228	Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed	2/13/2004	To protect the fiscal integrity of the Medicaid program, the Administrator of CMS should establish criteria for making transition period decisions that are consistent with the objectives described in CMS's January 2001 UPL regulation.	Closed, Unimplemented	Non-concur
GAO-04-228	Medicaid: Improved Federal Oversight of State Financing Schemes Is Needed	2/13/2004	To protect the fiscal integrity of the Medicaid program, the Administrator of CMS should reconsider the agency's initial decisions to grant Nebraska and Wisconsin 8-year transition periods.	Closed, Unimplemented	Non-concur
GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	To ensure that approved Pharmacy Plus and other Medicaid section 1115 demonstrations fulfill the objectives stated in their evaluation plans, the Secretary of HHS should ensure that states are taking appropriate steps to develop evaluation designs and to implement them by collecting and reporting the specific information needed for a full evaluation of the demonstration objectives.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should document and make public the basis for any section 1115 demonstration approvals, including the basis for the cost and enrollment growth rates used to arrive at the spending limits.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should consider applying these criteria to the four approved Pharmacy Plus demonstrations and reconsider the approval decisions, as appropriate.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-480	Medicaid Waivers: HHS Approvals of Pharmacy Plus Demonstrations Continue to Raise Cost and Oversight Concerns	6/30/2004	To improve HHS's process for reviewing and approving states' budget neutrality proposals for Pharmacy Plus and other Medicaid section 1115 demonstrations, the Secretary of HHS should, for future demonstrations, clarify criteria for reviewing and approving states' proposed spending limits.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	To create incentives for facilities to maintain compliance with Medicare quality standards, the Administrator of CMS should establish a goal for state agencies to reduce the time between surveys for facilities with condition-level deficiencies.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	To create incentives for facilities to maintain compliance with Medicare quality standards, the Administrator of CMS should publish facilities' survey results on its Dialysis Facility Compare Web site.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	To help surveyors identify and systematically document deficiencies, the Administrator of CMS should strongly encourage states to assign ESRD inspections to a designated subset of surveyors who specialize in conducting ESRD surveys.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	To enhance the support and monitoring of state survey agencies, the administrator of CMS should amend its regulations to require that networks share facility-specific data with state agencies on a routine basis.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-04-63	Dialysis Facilities: Problems Remain in Ensuring Compliance with Medicare Quality Standards	6/30/2004	To enhance the support and monitoring of state survey agencies, the administrator of CMS should ensure that regional offices both adequately monitor state performance and provide state agencies ongoing assistance on policy and technical issues through regularly scheduled contacts with state surveyors.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-709	Comprehensive Outpatient Rehabilitation Facilities: High Medicare Payments in Florida Raise Program Integrity Concerns	8/12/2004	To ensure that Medicare only pays for medically necessary care as outlined in program rules, the Centers for Medicare and Medicaid Services should direct the Florida claims administration contractor to medically review a larger number of CORF claims.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	The Administrator of CMS should gather the necessary data and perform an analysis that compares the types and costs of services on single-service claims to those on multiple-service claims.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	The Administrator of CMS should analyze the effect that the variation in hospital charge-setting practices has on the OPPS rate-setting methodology.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-772	Medicare: Information Needed to Assess Adequacy of Rate-Setting Methodology for Payments for Hospital Outpatient Services	9/17/2004	The Administrator of CMS should, in the context of the first two recommendations, analyze whether the OPPS rate-setting methodology results in payment rates that uniformly reflect hospitals' costs of the outpatient services they provide to Medicare beneficiaries, and, if it does not, make appropriate changes in that methodology.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare conditions of participation (COPs), the Administrator of CMS should modify the method used to measure the rate of disparity between validation survey findings and accreditation program findings to provide a reasonable assurance that Medicare COPs are being met and consider whether additional measures are needed to accurately reflect an accreditation program's ability to detect deficiencies in Medicare COPs.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare COPs, the Administrator of CMS should provide in the annual report to Congress an estimate, based on the validation survey sample, of the performance of all JCAHO-accredited hospitals, including the limitations and protocols for these estimates based on generally accepted sampling and statistical methodologies; and develop a written protocol for these calculations.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-04-850	Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals	7/20/2004	To strengthen the ability of CMS to identify and report to Congress on JCAHO's ability to ensure that the hospitals it accredits protect the safety and health of patients through compliance with the Medicare COPs, the Administrator of CMS should annually conduct traditional validation surveys on a sample of JCAHO-accredited hospitals that is equal to at least 5 percent of all JCAHO-accredited hospitals.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-119	Medicare Physician Fees: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement	3/11/2005	The Secretary of Health and Human Services should seek to improve the GPCI's data and methods by adding data on physician assistants' wages to improve the measurement of the practice expense GPCI.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-366	Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities	4/22/2005	To help ensure that IRFs can be classified appropriately and that only patients needing intensive inpatient rehabilitation are admitted to IRFs, the CMS Administrator should conduct additional activities to encourage research on the effectiveness of intensive inpatient rehabilitation and the factors that predict patient need for intensive inpatient rehabilitation.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-366	Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities	4/22/2005	To help ensure that IRFs can be classified appropriately and that only patients needing intensive inpatient rehabilitation are admitted to IRFs, the CMS Administrator should use the information obtained from reviews for medical necessity, research activities, and other sources to refine the rule to describe more thoroughly the subgroups of patients within a condition that are appropriate for IRFs rather than other settings, and may consider using other factors in the descriptions, such as functional status.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-43	Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs	11/17/2004	To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, the Administrator of CMS should develop a process within CMS to focus on trends in Medicare spending and disproportionate or suspicious Medicare payments; develop strategies to address the trends that may indicate possible improper payments for DME; and take timely action, when warranted.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-43	Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs	11/17/2004	To help ensure that improper payments are identified and addressed in a timely manner and that Medicare pays properly for power wheelchairs and other items of DME, the Administrator of CMS should strengthen the standards for Medicare DME suppliers to include prohibiting certain misleading or abusive marketing practices.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should prepare a detailed project plan to include interim and final milestones, individuals or groups responsible for completing key elements essential to the transfer, and contingency plans.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should validate data and perform analyses to support decisions regarding key elements, such as workload, staffing needs, and costs.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should outline a strategy that addresses the possible need for two separate processing systems at HHS--one for appeals that follows the current processing practices and one that complies with BIPA's time frames and other requirements--in the event that the BIPA provisions establishing the QICs are not implemented as scheduled.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should identify where staff and hearing facilities--including videoconference equipment--are needed as well as opportunities to share staff and office space.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should develop an approach to ensure that ALJs and support staff with Medicare expertise can be hired, and that all staff are adequately trained to process and adjudicate Medicare appeals.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-45	Medicare: Incomplete Plan to Transfer Appeals Workload from SSA to HHS Threatens Service to Appellants	10/4/2004	To help ensure a smooth and timely transition of the Medicare appeals workload from SSA to HHS, the Secretary of HHS and the Commissioner of SSA should take steps to complete a substantive and detailed transfer plan. Specifically, the Secretary and Commissioner should define the relationship of HHS's ALJ unit to the other organizations within the department, and identify safeguards that will be established to ensure decisional independence.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	To provide for a more appropriate basis for adjusting BIPA PPS payment rates for FQHCs and RHCs, the Administrator of CMS should explore the development of an inflation index that better captures the cost of services provided by or price of resources used by FQHCs and RHCs and propose to Congress, as appropriate, any needed revisions to the statute.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' Medicaid plans provide sufficient information describing their methodologies for paying FQHCs and RHCs for Medicaid services, including, at a minimum, whether the state is using the BIPA PPS or an alternative methodology.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should develop guidance for states describing what constitutes a change in scope of services provided by FQHCs and RHCs, including the definition of the specific elements that affect such a change.	Closed, Unimplemented	Non-concur
GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' FQHC and RHC BIPA PPS payment rates do not inappropriately exclude the costs of Medicaid-covered services.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-452	Health Centers And Rural Clinics: State and Federal Implementation Issues for Medicaid's New Payment System	6/17/2005	To better ensure consistent state compliance with the BIPA-mandated Medicaid payment requirements for FQHCs and RHCs, the Administrator of CMS should ensure that states' alternative payment methodologies are paying FQHCs and RHCs at least as much as what would be paid under the BIPA PPS, including any needed adjustments due to a change in scope of services.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-60	Medicare Physician Fee Schedule: CMS Needs a Plan for Updating Practice Expense Component	12/13/2004	To improve and update the physician fee schedule, the CMS Administrator should base any revisions to the resource estimates for individual services on sufficient data analysis and a documented and transparent rationale.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents, such as state plan amendment proposals.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents, such as cost allocation proposals.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should routinely request that states disclose their use of contingency-fee consultants when submitting state Medicaid documents and in the event that states do not voluntarily provide this information, seek legislative authority to require disclosure.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should enhance CMS review of states' Medicaid documents, such as such as cost allocation plans, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should enhance CMS review of states' Medicaid documents, such as expenditure reports, specifically reviewing payments states make to units of government, including the methodology behind payment rates to government units and the basis for any related claims, and take appropriate action to prevent or recover unallowable claims.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should establish or clarify and then communicate CMS policies on rehabilitation services and ensure that the policies are applied consistently across all states.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should require that states identify--in Medicaid-related documents such as expenditure reports-- claims for payments to units of state or local government, such as state- and local-government-owned or -operated facilities.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To improve CMS's oversight of projects involving contingency-fee consultants and any associated claims for federal Medicaid reimbursements, the Administrator of CMS should enhance CMS review of state Medicaid documents for which states have used a contingency-fee consultant and take appropriate action to prevent or recover federal reimbursements associated with unallowable claims.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-05-748	Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight	6/28/2005	To strengthen CMS's overall financial management of state Medicaid activities, the Administrator of CMS should ensure that states submit cost allocation plans as required and establish a procedure for their prompt review.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-05-873	Medicare Contracting Reform: CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain	8/17/2005	To better ensure the effective implementation of Medicare contracting reform, CMS should extend its implementation schedule to complete its workload transitions by October 2011, so that the agency can be better prepared to manage this initiative.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceuticals Used in Hospitals	10/31/2005	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should reconsider the level of proposed payment rates for drug SCODs, in relation to survey data on average purchase price, the role of rebates in determining acquisition costs, and the desirability of setting payment rates for SCODs at average acquisition costs.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceuticals Used in Hospitals	10/31/2005	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should reconsider the decision to base payment rates for radiopharmaceutical SCODs exclusively on estimated costs, in light of the availability of data on actual prices paid for key radiopharmaceuticals.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-17R	Medicare: Comments on CMS Proposed 2006 Rates for Specified Covered Outpatient Drugs and Radiopharmaceuticals Used in Hospitals	10/31/2005	To better approximate hospitals' acquisition costs of SCODs, the Secretary of Health and Human Services should collect information on ASP components and ASP by purchaser type to validate the reasonableness of reported ASPs as a measure of hospital acquisition costs.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-372	Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-Setting Challenges for CMS	4/28/2006	To ensure that Medicare payments for SCOD products are based on sufficiently accurate data, the Secretary of Health and Human Services should validate, on an occasional basis, manufacturers' reported drug ASPs as a measure of hospitals' acquisition costs using a survey of hospitals or other method that CMS determines to be similarly accurate and efficient.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-06-372	Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-Setting Challenges for CMS	4/28/2006	To ensure that Medicare payments for SCOD products are based on sufficiently accurate data, the Secretary of Health and Human Services should use unit-dose prices paid by hospitals when available as the data source for setting and updating Medicare payment rates for radiopharmaceutical SCODs.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	To ensure consistency in the oversight of labs by survey organizations, the CMS Administrator should require all survey organizations to develop, and require labs to prominently display, posters instructing lab workers on how to file anonymous complaints.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	To improve oversight of labs and survey organizations, the CMS Administrator should, consistent with CLIA, require quarterly proficiency testing, except when technical and scientific considerations suggest that less frequent testing is appropriate for particular examinations or procedures.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-416	Clinical Lab Quality: CMS and Survey Organization Oversight Should Be Strengthened	6/16/2006	To improve oversight of labs and survey organizations, the CMS Administrator should require that almost all validation reviews of each accrediting organizations' surveys be an independent assessment of performance.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-06-54	Hospital Quality Data: CMS Needs More Rigorous Methods to Ensure Reliability of Publicly Released Data	1/31/2006	In order for CMS to help ensure the reliability of the quality data it uses to produce information on hospital performance, the CMS Administrator should assess the level of incomplete data submitted by hospitals for the APU program to determine the magnitude of underreporting, if any, in order to refine how completeness assessments may be done in future reporting efforts.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-214	Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency	3/30/2007	To enhance the transparency of CMS oversight and clarify and communicate the types of allowable state financing arrangements, the Administrator of CMS should issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents	3/26/2007	To address weaknesses that undermine the effectiveness of the immediate sanctions policy, the Administrator of CMS should reassess and revise the policy to ensure that it accomplishes the following three objectives: (1) reduce the lag time between citation of a double G and the implementation of a sanction, (2) prevent nursing homes that repeatedly harm residents or place them in immediate jeopardy from escaping sanctions, and (3) hold states accountable for reporting in federal data systems serious deficiencies identified during complaint investigations so that all complaint findings are considered in determining when immediate sanctions are warranted.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents	3/26/2007	To strengthen the deterrent effect of available sanctions and to ensure that sanctions are used to their fullest potential, the Administrator of CMS should increase use of discretionary DPNAs to help ensure the speedier implementation of appropriate sanctions.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-241	Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents	3/26/2007	To strengthen the deterrent effect of available sanctions and to ensure that sanctions are used to their fullest potential, the Administrator of CMS should strengthen the criteria for terminating homes with a history of serious, repeated noncompliance by limiting the extension of termination dates, increasing the use of discretionary terminations, and exploring alternative thresholds for termination, such as the cumulative duration of noncompliance.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-272	Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries	5/4/2007	To support states with the relevant authority that want to use alternative enrollment methods to reassign dual-eligible beneficiaries to PDPs, the Administrator of CMS should facilitate the sharing of data between PDPs and states.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-373	Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations	5/29/2007	To improve monitoring of QIO assistance to nursing homes and to overcome limitations of the QMs as an evaluation tool, the Administrator of CMS should collect more complete and detailed data on the interventions QIOs are using to assist homes.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-07-383	Ambulance Providers: Costs and Expected Medicare Margins Vary Greatly	5/23/2007	In light of the variability in ambulance providers' Medicare margins and the potential for negative margins to have an impact on beneficiary access, the Administrator of the Centers for Medicare and Medicaid Services should monitor utilization of ambulance transports to ensure that Medicare payments are adequate to provide for beneficiary access to ambulance services, particularly in super-rural areas.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-466	Medicare: Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised	6/29/2007	To help ensure that Medicare's payments to physicians more accurately reflect geographic differences in physicians' costs of operating a private medical practice, the Administrator of CMS should examine and revise the physician payment localities using an approach that is uniformly applied to all states and based on the most current data.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-466	Medicare: Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised	6/29/2007	To help ensure that Medicare's payments to physicians more accurately reflect geographic differences in physicians' costs of operating a private medical practice, the Administrator of CMS should examine and, if necessary, update the physician payment localities on a periodic basis with no more than 10 years between updates.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-07-734	Medicare Ultrasound Procedures: Consideration of Payment Reforms and Technician Qualification Requirements	6/28/2007	The Administrator of CMS should require that sonographers paid by Medicare either be credentialed or work in an accredited facility. The Administrator should weigh the advantages and disadvantages of implementing a National Coverage Determination compared with promulgating regulations that this requirement be a condition for Medicare payment.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-07-945	Medicare Advantage: Required Audits of Limited Value	7/30/2007	To help fulfill CMS's responsibilities, the Administrator of CMS should amend the implementing regulations for the Medicare Advantage Program and Prescription Drug Program to provide that all contracts CMS enters into with Medicare Advantage organizations and prescription drug plan sponsors include terms that inform these organizations of the audits and give CMS authority to address identified deficiencies, including pursuit of financial recoveries. If CMS does not believe it has the authority to amend its implementing regulations for these purposes, it should ask Congress for express authority to do so.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-08-529	Medicaid Home and Community-Based Waivers: CMS Should Encourage States to Conduct Mortality Reviews for Individuals with Developmental Disabilities	5/23/2008	To provide additional oversight of the quality of care provided to these individuals, the Administrator of CMS should establish as an expectation for HCBS waivers that state Medicaid agencies report all deaths among individuals with developmental disabilities receiving such waiver services to their state office of protection and advocacy.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-08-614	Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments	5/30/2008	To improve the oversight of states' Medicaid supplemental payments, the Administrator of CMS should develop a strategy to identify all of the supplemental payment programs established in states' Medicaid plans and to review those programs that have not been subject to review under CMS's August 2003 initiative.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-08-87	Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns	1/31/2008	To help ensure that the Florida demonstration will maintain the fiscal integrity of the Medicaid program, the Secretary of HHS should ensure that the level of supplemental payments for which the state could have obtained federal Medicaid funds in the absence of the proposed demonstration is calculated using appropriate methods and accurate data sources, and adjust the approved spending limit appropriately.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-09-118	Debt Management: Treasury's Cash Management Challenges and Timing of Payments to Medicare Private Plans	1/30/2009	The Secretary of the Treasury and the Administrator of CMS should expeditiously convene a joint interagency effort to study options identified by GAO and any other options that would improve Treasury's ability to manage cash flow and reduce overall interest costs while not unduly increasing administrative burden for CMS. For each option, the joint study should include discussion of (1) operational impacts on and likely consequences for cash management, CMS, and Treasury operations; (2) plan sponsors' likely responses and the consequences of these for the Medicare program and beneficiaries; (3) the expected change in federal costs and the distribution of any increases or decreases; (4) analysis of feasibility and mechanics of varying payment schedule by size/scale of plan; and (5) what would be needed for implementation, including which options would require statutory change and if so the specific changes necessary. Based on the work done and our discussions with Treasury officials, we believe it is reasonable for this study to be completed by the end of CY 2009.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-25	Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans	2/15/2008	The Acting Administrator of Centers for Medicare and Medicaid Services (CMS) should investigate the extent to which beneficiaries in PFFS plans are faced with unexpected out-of-pocket costs due to the denial of coverage when they did not obtain an advance coverage determination from their plan.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-25	Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans	2/15/2008	The Acting Administrator of Centers for Medicare and Medicaid Services (CMS) should mail to Medicare beneficiaries MA plan disenrollment rates for the previous 2 years for MA plans that are or will be available in their areas, as required by statute, and update disenrollment rates provided to Medicare beneficiaries through MOC.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to ensure that Congress has adequate information on the impact of funding on facility oversight, the CMS Administrator should inform Congress of the projected cost of surveying all facilities that lack statutorily mandated survey frequencies a minimum of at least once every 3 years.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to ensure that Congress has adequate information on the impact of funding on facility oversight, the CMS Administrator should include information in the President's budget request on projected state complaints and the cost of completing the associated workload.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-64	Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities	2/13/2009	To address significant shortcomings in the current system for financing and conducting surveys of Medicare and Medicaid facilities, and to improve CMS's ability to differentiate between funding and management issues and help ensure the quality of surveys, the CMS Administrator should provide Congress with an estimate of the cost of implementing, over 3 years, the Quality Indicator Survey methodology for nursing homes.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	To improve the targeting of scarce survey resources, the Administrator of CMS should consider an alternative approach for allocating the 136 SFFs across states, by placing more emphasis on the relative performance of homes nationally rather than on a state-by-state basis, which could result in some states having only one or not any SFFs and other states having more than they are currently allocated.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	To improve the SFF methodology's ability to identify the most poorly performing nursing homes, the Administrator of CMS should assign points to G-level deficiencies in substandard quality of care (SQC) areas equivalent to those additional points assigned to H- and I-level deficiencies in SQC areas.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	To improve the SFF methodology's ability to identify the most poorly performing nursing homes, the Administrator of CMS should account for a nursing home's full compliance history regardless of technical status changes.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-09-689	Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit	8/28/2009	To ensure consistency with the SFF methodology, CMS should consider making two of these modifications--the SQC and full compliance history changes--to its Five Star System.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-70	Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment	11/24/2009	To address surveyor workforce shortages and insufficient training, the Administrator of CMS should consider establishing a pool of additional national surveyors that could augment state survey teams or identify other approaches to help states experiencing workforce shortages.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	The Secretary should consider mandating the reporting of the following types of information: The organizational structure and the relationships to the facility and to one another of all persons or entities with direct or indirect ownership or control interests in the provider, such that the hierarchy of all intermediate persons and entities from the provider level up to the chain and the ultimate owner is described;	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	The Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the names and titles of the members of the chains' governing body.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	The Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational affiliation of individuals with an ownership or control interest (as defined in the act).	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	To ensure that all providers that belong to the same nursing home chain can be readily identified, the Administrator of CMS should require each provider to report the identity of other nursing homes that are part of the same chain.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	To improve the usability and accuracy of the ownership and control information collected and stored in PECOS, the Administrator of CMS should examine state systems to identify best practices for the collection and public dissemination of nursing home ownership and chain information, including ways in which states make the hierarchy among owners more apparent.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	NURSING HOMES: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	10/27/2010	To help ensure that the requirements for the collection of ownership and control information from nursing home providers that participate in Medicare and Medicaid keep pace with evolving ownership structures, the Administrator of CMS should periodically review the requirements related to reporting on the agency's provider enrollment form to ensure that it promotes accurate and complete reporting of nursing home ownership information consistent with the statute.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational structure and the relationships to the facility and to one another of all persons or entities with direct or indirect ownership or control interests in the provider (as defined in the act), such that the hierarchy of all intermediate persons and entities from the provider level up to the chain and the ultimate owner is described.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the names and titles of the members of the chains' governing body.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	As the Secretary of HHS develops regulations to implement the expanded nursing home ownership reporting and disclosure requirements contained in the Patient Protection and Affordable Care Act, the Secretary, given the complex arrangements under which nursing homes can be acquired and operated, should consider requiring the reporting of the organizational affiliation of individuals with an ownership or control interest (as defined in the act).	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	To ensure that all providers that belong to the same nursing home chain can be readily identified, the Administrator of CMS should require each provider to report the identity of other nursing homes that are part of the same chain.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	To improve the usability and accuracy of the ownership and control information collected and stored in PECOS, the Administrator of CMS should examine state systems to identify best practices for the collection and public dissemination of nursing home ownership and chain information, including ways in which states make the hierarchy among owners more apparent.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-10-710	Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data	9/30/2010	To help ensure that the requirements for the collection of ownership and control information from nursing home providers that participate in Medicare and Medicaid keep pace with evolving ownership structures, the Administrator of CMS should periodically review the requirements related to reporting on the agency's provider enrollment form to ensure that it promotes accurate and complete reporting of nursing home ownership information consistent with the statute.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-11-159	Electronic Prescribing: CMS Should Address Inconsistencies in Its Two Incentive Programs That Encourage the Use of Health Information Technology	2/17/2011	To help ensure that Electronic Prescribing Program resources are used appropriately, the Administrator of CMS should develop a risk-based strategy to audit a sample of providers who received incentive payments from the Electronic Prescribing Program to help ensure that providers who receive incentive payments meet that program's requirements. A risk-based strategy could, for example, focus on those providers who received larger incentive payments.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-11-280	Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations	4/17/2011	To strengthen CMS's assessment of state survey agencies' performance in the management of nursing home complaints, the Administrator of CMS should assess state survey agencies' performance in certain areas--specifically, documentation of deficiencies, prioritization of complaints, and quality of investigations--less frequently than once a year.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-11-365	End-Stage Renal Disease: CMS Should Assess Adequacy of Payment When Certain Oral Drugs Are Included and Ensure Availability of Quality Monitoring Data	3/23/2011	In order to ensure effective monitoring of treatment of mineral and bone disorder, the Administrator of CMS should continue collecting data for quality measures related to this condition from sources such as the Elab Project until CROWNWeb is fully implemented and concerns about its data reliability have been adequately addressed.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-11-446	Health Care Fraud and Abuse Control Program: Improvements Needed in Controls over Reporting Deposits and Expenditures	5/10/2011	To improve controls over the accounting and reporting of HCFAC activities, the Secretary of HHS should direct the Administrator of CMS to revise procedures for properly maintaining supporting documentation for HCFAC deposits and expenditures, to include specifying the titles of staff responsible for maintaining supporting documentation.	Closed, Unimplemented	Non-concur
GAO-11-446	Health Care Fraud and Abuse Control Program: Improvements Needed in Controls over Reporting Deposits and Expenditures	5/10/2011	To improve controls over the accounting and reporting of HCFAC activities, the Secretary of HHS should direct the Acting General Counsel to develop written procedures that incorporate monitoring controls for the Office of the General Counsel staff hours related to HCFAC activities captured in workload tracking systems, including the reconciliation to staff hours captured in the department wide payroll system.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-11-475	Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use	6/12/2011	To help ensure that the development and implementation of IDR and One PI are successful in helping the agency meet the goals and objectives of its program integrity initiatives, the Administrator of CMS should define any measurable financial benefits expected from the implementation of IDR and One PI.	Closed, Unimplemented	Updated action, recommended closure to GAO
GAO-11-475	Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use	6/30/2011	To help ensure that the development and implementation of IDR and One PI are successful in helping the agency meet the goals and objectives of its program integrity initiatives, the Administrator of CMS should define any measurable financial benefits expected from the implementation of IDR and One PI.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-11-56	Medicare Home Oxygen: Refining Payment Methodology Has Potential to Lower Program and Beneficiary Spending	1/21/2011	To establish rates that more accurately reflect the distinct costs of providing each type of home oxygen equipment, the Administrator of CMS should restructure Medicare's home oxygen payment methodology. This should include removing the payment for portable oxygen refills from that for stationary equipment and paying for refills only for the equipment types that require them.	Closed, Unimplemented	Non-concur, recommendation is no longer valid

GAO-12-390	Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met	3/23/2012	In order to strengthen CMS's efforts to improve the Five-Star System, the Administrator of CMS should use strategic planning practices to establish -- through planning documents -- how its planned efforts will help CMS achieve the goals of the Five-Star System.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-390	Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met	3/23/2012	In order to strengthen CMS's efforts to improve the Five-Star System, the Administrator of CMS should use strategic planning practices to develop milestones and timelines for each of its planned efforts.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-409R	Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings	3/21/2012	The Secretary of HHS should cancel the MA Quality Bonus Payment Demonstration and allow the MA quality bonus payment system established by PPACA to take effect. If, at a future date, the Secretary finds that this system does not adequately promote quality improvement, HHS should determine ways to modify the system, which could include conducting an appropriately designed demonstration.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-481	Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements	4/30/2012	In order to improve the efficiency and effectiveness of processes to verify whether providers meet program requirements for the Medicare and Medicaid EHR programs, the Administrator of CMS should collect the additional information from Medicare providers during attestation that CMS suggested states collect from Medicaid providers during attestation.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-481	Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements	4/30/2012	In order to improve the efficiency and effectiveness of processes to verify whether providers meet program requirements for the Medicare and Medicaid EHR programs, the Administrator of CMS should offer states the option of having CMS collect meaningful use attestations from Medicaid providers on their behalf.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-12-61	Medicare: Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations	12/15/2011	To help improve the ability of Medicare beneficiaries to obtain routinely recommended vaccinations, the Administrator of CMS should explore options and take appropriate steps to address administrative challenges, such as physicians' difficulty in verifying beneficiaries' coverage and billing for Part D-covered vaccinations.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-627	NATIONAL MEDICAID AUDIT PROGRAM: CMS Should Improve Reporting and Focus on Audit Collaboration with States	12/1/2011	The CMS Administrator should ensure that the MIG's planned update of its comprehensive plan: 1) quantifies the NMAP's expenditures and recoveries; 2) addresses any program improvements; and 3) outlines plans for effectively monitoring the NMAP program, including how to validate and use any lessons learned or feedback from the States to continuously improve the audits.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-627	National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States	6/14/2012	To effectively redirect the NMAP toward more productive outcomes and to improve reporting under the Deficit Reduction Act of 2005 (DRA), the CMS Administrator should ensure that the MIG's planned update of its comprehensive plan (1) quantifies the NMAP's expenditures and audit outcomes; (2) addresses any program improvements; and (3) outlines plans for effectively monitoring the NMAP program, including how to validate and use any lessons learned or feedback from the states to continuously improve the audits.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-831	Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards	8/1/2012	In order for CMS to implement an option for removing SSNs from Medicare cards, the Administrator of CMS should develop an accurate, well-documented cost estimate for such an option using standard cost-estimating procedures.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should require D-SNPs to state explicitly in their models of care the extent of services they expect to provide, to increase accountability and to facilitate evaluation.	Closed, Unimplemented	OpDiv considers requested actions completed

GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should require D-SNPs to collect and report to CMS standard performance and outcome measures to be outlined in their models of care that are relevant to the population they serve, including measures of beneficiary health risk, beneficiary vulnerability, and plan performance.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-12-864	Medicare Special Needs Plans: CMS Should Improve Information Available about Dual-Eligible Plans' Performance	9/13/2012	To increase D-SNPs' accountability and ensure that CMS has the information it needs to determine whether D-SNPs are providing the services needed by dual-eligible beneficiaries, especially those who are most vulnerable, the Administrator of CMS should systematically analyze these data and make the results routinely available to the public.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-13-522	Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency	7/23/2013	In order to improve the efficiency and effectiveness of Medicare program integrity efforts and simplify compliance for providers, the Administrator of CMS should communicate publicly CMS's findings and its time frame for taking further action.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-14-111	MEDICARE PROGRAM INTEGRITY: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	11/25/2013	The CMS should collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, such as how soon investigations are initiated after ZPICs identify potential fraud and how swiftly ZPICs initiate administrative actions after identifying potentially fraudulent providers.	Closed, Unimplemented	Updated action, recommended closure to GAO
GAO-14-111	MEDICARE PROGRAM INTEGRITY: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	11/25/2013	The CMS should develop ZPIC performance measures that explicitly link their work to the agency's Medicare fee-for-service program integrity performance measures and targets for its GPRA goal of fighting fraud and working to eliminate improper payments.	Closed, Unimplemented	Updated action, recommended closure to GAO

GAO-14-111	Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	10/25/2013	To help ensure that CMS's fraud prevention activities are effective and that CMS is comprehensively assessing ZPIC performance, the Administrator of CMS should collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, such as how soon investigations are initiated after ZPICs identify potential fraud and how swiftly ZPICs initiate administrative actions after identifying potentially fraudulent providers.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-14-111	Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight	10/25/2013	To help ensure that CMS's fraud prevention activities are effective and that CMS is comprehensively assessing ZPIC performance, the Administrator of CMS should develop ZPIC performance measures that explicitly link their work to the agency's Medicare fee-for-service program integrity performance measures and targets for its GPRA goal of fighting fraud and working to eliminate improper payments.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-14-697	Patient Protection And Affordable Care Act: Procedures for Reporting Certain Financial Management Information Should Be Improved	9/22/2014	The Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare and Medicaid Services to identify and evaluate options to facilitate more timely and independently verifiable reporting of CCIIO-related financial management information, such as enhancing Healthcare Integrated General Ledger Accounting System's standard reporting or custom reporting capabilities.	Closed, Unimplemented	Non-concur

GAO-15-207	Medicaid Information Technology: CMS Supports Use of Program Integrity Systems but Should Require States to Determine Effectiveness	1/30/2015	To ensure that the federal government's and states' investments in information systems result in outcomes that are effective in supporting efforts to save funds through the prevention and detection of improper payments in the Medicaid program, the Secretary of Health and Human Services should direct the Administrator of CMS to require states to measure quantifiable benefits, such as cost reductions or avoidance, achieved as a result of operating information systems to help prevent and detect improper payments. Such measurement of benefits should reflect a consistent and repeatable approach and should be reported when requesting approval for matching federal funds to support ongoing operation and maintenance of systems that were implemented to support Medicaid program integrity purposes.	Closed, Unimplemented	Non-concur
GAO-15-527	CMS Should Improve Oversight of State Information Technology Projects	9/16/2015	To improve the oversight of states' marketplace IT projects, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to ensure that all CMS senior executives from IT and business units who are involved in the establishment of state marketplace IT projects review and approve funding decisions for these projects.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-15-527	State Health Insurance Marketplaces: CMS Should Improve Oversight of State Information Technology Projects	9/16/2015	To improve the oversight of states' marketplace IT projects, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to ensure that all CMS senior executives from IT and business units who are involved in the establishment of state marketplace IT projects review and approve funding decisions for these projects.	Closed, Unimplemented	Updated action, recommended closure to GAO

GAO-15-85	Compounded Drugs: Payment Practices Vary across Public Programs and Private Insurers, and Medicare Part B Policy Should Be Clarified	10/10/2014	To help ensure that Medicare Part B is able to appropriately apply its payment policy for compounded drugs, the Secretary of Health and Human Services should direct the Administrator of the Centers for Medicare & Medicaid Services to clarify the Medicare Part B payment policy for compounded drugs and, as necessary, align payment practices with the policy. For example, CMS should consider updating the Medicare Part B payment policy to either explicitly allow or restrict payment for compounded drugs containing bulk drug substances and, as appropriate, develop a mechanism to indicate on Medicare Part B claims both whether a beneficiary received a compounded drug and the drug's individual ingredients in order to properly apply this policy and determine payment.	Closed, Unimplemented	Non-concur
HEHS/AIMD-00-304	Medicare: HCFA Could Do More to Identify and Collect Overpayments	9/7/2000	To improve overpayment identification and collection, the Administrator, HCFA, should require that the effectiveness of prepayment and postpayment activities be evaluated to determine the relative benefits of various prepayment and postpayment safeguards.	Closed, Unimplemented	OpDiv considers requested actions completed
HEHS/OSI-00-69	Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight	4/5/2000	In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, the Administrator, HCFA, should allow the use of bundled rates as one of several alternative payment approaches, provided that HCFA establishes consistent principles for bundling that effectively address: (1) provisions for rates that reflect or recognize varying levels of services to accommodate children; and (2) assurances that children receive appropriate and needed services.	Closed, Unimplemented	OpDiv considers requested actions completed

HEHS/OSI-00-69	Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight	4/5/2000	In order to improve the development and application of policies for Medicaid reimbursement of claims for allowable school-based health services and administrative activities, the Administrator, HCFA, should clarify the agency's policy on specialized transportation, with the goal of establishing policies that offer equitable treatment for children with different types of disabilities.	Closed, Unimplemented	OpDiv considers requested actions completed
HEHS-00-114	Medicare Quality of Care: Oversight of Kidney Dialysis Facilities Needs Improvement	6/23/2000	The Administrator, HCFA, should strengthen HCFA's oversight of ESRD facilities by developing procedures on how and when to use HCFA's existing authority to impose partial or complete payment reductions for ESRD facilities that do not meet Medicare quality standards for dialyzer reuse.	Closed, Unimplemented	OpDiv considers requested actions completed
HEHS-00-9	Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available	4/7/2000	In order to minimize unintended consequences on beneficiaries, HHAs, and Medicare, and to narrow information gaps in the PPS design, the Administrator, HCFA, should incorporate a risk-sharing arrangement into the PPS design, consistent with methods tested in the demonstration, until available analyses indicate that it is no longer needed to protect beneficiaries, HHAs, or the Medicare program.	Closed, Unimplemented	OpDiv considers requested actions completed
OEI-03-08-00030	Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors	12/15/2011	Require all benefit integrity contractors to report monetary impact, when calculable, in a consistent format	Closed, Unimplemented	Non-concur
T-AIMD-00-118	Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability	3/15/2000	To improve financial management and accountability in the Medicare program, the Administrator, HCFA, should direct the Chief Financial Officer to improve procedures for evaluating and resolving findings from annual financial statements audits by developing, documenting, and implementing procedures so that managers promptly evaluate audit findings, determine proper actions in response to audit findings, and complete within established timeframes all actions that resolve the findings brought to management's attention.	Closed, Unimplemented	OpDiv considers requested actions completed

A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	The OIG recommends that CMS direct the Medicare contractors to recover the portion of the $8,633,940 in improper payments made to providers for claim lines that are within the 4-year claim-reopening period.	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	The OIG recommends that for the remaining portion of the $8,633,940, which is outside of the Medicare reopening and recovery periods, CMS instruct the Medicare contractors to notify providers of potential improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation.	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-17-03018	Medicare Improperly Paid Providers for Nonemergency Ambulance Transports to Destinations Not Covered by Medicare	7/11/2018	The OIG recommends that CMS direct the Medicare contractors to review claim lines for nonemergency ambulance transports to destinations not covered by Medicare after the audit period and recover any improper payments identified.	Closed, Unimplemented	OpDiv considers requested actions completed
AIMD-00-66	Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability	3/15/2000	To improve financial management and accountability in the Medicare program, the Administrator, HCFA, should direct the Chief Financial Officer to improve procedures for evaluating and resolving findings from annual financial statements audits by developing, documenting, and implementing procedures so that managers promptly evaluate audit findings, determine proper actions in response to audit findings, and complete within established timeframes all actions that resolve the findings brought to management's attention.	Closed, Unimplemented	OpDiv considers requested actions completed
GAO-13-561	Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight	7/15/2003	To better ensure that state survey and complaint activities adequately address quality-of-care problems, the Administrator of CMS should require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.	Closed, Unimplemented	OpDiv considers requested actions completed

A-05-14-00041	Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements	3/14/2018	Instruct the MACs to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments made in accordance with this recommendation.	Closed, Unimplemented	Non-concur
A-06-16-05003	Medicare Contractors' Payments to Providers for Hospital Outpatient Dental Services Generally Did Not Comply With Medicare Requirements	3/1/2017	Work with the Medicare contractors to develop or strengthen their local edits to ensure that payments made to providers for dental services comply with Medicare requirements.	Closed, Unimplemented	OpDiv considers requested actions completed
A-06-16-05003	Medicare Contractors' Payments to Providers for Hospital Outpatient Dental Services Generally Did Not Comply With Medicare Requirements	3/1/2017	The OIG recommends that CMS implement national edits for hospital outpatient dental services.	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-16-02042	Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services	2/12/2018	CMS should educate beneficiaries on the types of chiropractic services that are covered by Medicare, inform them that massage and acupuncture services are not covered by Medicare, and encourage them to report to CMS chiropractors who are providing non-Medicare-coveredServices.	Closed, Unimplemented	Non-concur
A-09-16-02042	Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services	2/12/2018	CMS should identify chiropractors with aberrant billing patterns or high service-denial rates, select a statistically valid random sample of services provided by each chiropractor identified, review the medical records for the sampled services, estimate the amount overpaid to each chiropractor, and request that the chiropractors refund the amounts overpaid by Medicare.	Closed, Unimplemented	Non-concur

A-09-17-03002	Medicare Improperly Paid Providers for Items and Services Ordered by Chiropractors	7/5/2018	We recommend that CMS revise the claims processing edits to ensure that all claims for items and services ordered by chiropractors are denied.	Closed, Unimplemented	Non-concur
A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	We recommend that CMS direct the Medicare contractors to recover the portion of the $975,154 in improper payments made to providers for claim lines for emergency ambulance transports to destinations not covered by Medicare that are within the 4-year claim-reopening period.	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	We recommend that CMS direct the Medicare contractors to review claim lines that are within the 4-year claim-reopening period for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports and recover any improper payments identified, which could represent $928,092 in improper payments.	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	We recommend that CMS for the remaining portion of the $1,903,246, which is outside of the Medicare reopening and recovery periods, instruct the Medicare contractors to notify providers of potentially improper payments so that those providers can exercise reasonable diligence to investigate and return any identified similar improper payments in accordance with the 60-day rule, and identify and track any returned improper payments as having been made in accordance with this recommendation	Closed, Unimplemented	OpDiv considers requested actions completed
A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	We recommend that CMS direct the Medicare contractors to review claim lines after our audit period for emergency ambulance transports to destinations not covered by Medicare and recover any improper payments identified.	Closed, Unimplemented	OpDiv considers requested actions completed

A-09-17-03017	Medicare Made Improper and Potentially Improper Payments for Emergency Ambulance Transports to Destinations Other Than Hospitals or Skilled Nursing Facilities	8/15/2018	We recommend that CMS based on the results of the Medicare contractors' review of emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports, consider (1) directing the Medicare contractors to review claim lines after our audit period and recover any improper payments identified and (2) requiring the Medicare contractors to implement nation-wide prepayment edits specific to emergency ambulance transports that would either deny payments or mandate prepayment review for emergency ambulance transports to destinations other than hospitals or SNFs that might have been covered by Medicare for nonemergency ambulance transports.	Closed, Unimplemented	OpDiv considers requested actions completed